5 May 2007
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Lord Hunt bullish over pharmacy

CCA backs US drug watch scheme

STOP THE SWITCH

- Simvastatin switch could save billions
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C+D

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Cover: This week's Pharmacy Champion, Kay Crockatt. Picture: Mike Smith

Stakeholders debate key issues of royal college membership

Representatives support leadership body but remain divided over the detail

Tom Hawkins

The inclusion of technicians and pharmaceutical scientists as full members of a royal college was one of the key issues thrashed out by leading pharmacy bodies this week.

Representatives from 44 organisations gathered at the Royal Pharmaceutical Society's headquarters in Lambeth on Monday in response to the government's White Paper on health regulation. While the majority of attendees said they were in support of a leadership body, differing views were expressed on details such as membership.

Ian Simpson, chief executive of the College of Pharmacy Practice, said: "There was quite a bit of debate over whether it should be a body for pharmacy only or embrace technicians and scientists."

RPSGB Council member John Gentle said: "We wish to see full members of the royal college as qualified pharmacists but the royal college would work closely with other groups – technicians, dispensing staff, career-long pharmacists in industry."

Along with fellow Council member Andrew Gush, Mr Gentle this week tabled a motion for the May Council meeting, which proposes that the Society should identify affiliate bodies whose members benefit from paid services provided by the Society. He added that he hoped a vote would be held in public business to provide transparency.

Professor Ijeoma Uchegbu, chair of the Academy of Pharmaceutical Sciences, said membership should expand outside those pharmacists who will be registered with the General Pharmaceutical Council. She added that the RPSGB should lead on the discussion.

"We've had a lot of consultation and met with a lot of groups. Now it's time to move on and come out with a plan."

A report of the day's events will be issued later this month as a consultation document on the development of a royal college.

Lord Carter's report on the implementation of the General Pharmaceutical Council and a royal college has been handed to ministers and the Society. Lord Hunt will attend a Department of Health stakeholder meeting on June 5 to discuss it further.

He said: "I've got a copy of the Carter review and hope it will be published shortly. It provides a sensible way forward.

"I think the future royal college will provide marvellous leadership and our role at the department is to support that progress."

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Lambeth talk: pharmacy representatives met at the RPSGB headquarters on Monday

Read more views on the royal college. See pages 12 and 14

CCA offers MHRA innovative pseudoephedrine solution

Multiple pharmacy groups have thrown their weight behind an innovative scheme from the USA in their efforts to stop the P to POM switch of products containing pseudoephedrine and ephedrine.

Within its package of recommendations to the MHRA, the CCA says rather than making the medicines prescription-only pharmacists in the UK could employ a system such as MethGuard, which monitors sales patterns and is linked to a code of practice.

Steve Roden, chief executive of [illegible] which developed MethGuard, said the system would [illegible] pharmacists in the UK to learn [illegible] controls exercised in the USA.

"We have had extensive experience over the last few years with this [illegible] drug and how to sensibly deal with [illegible] in a way that is not over the top from a consumer and healthcare cost perspective."

The CCA, like many other pharmacy organisations, has backed C+D's Stop the Switch campaign against the MHRA's proposals. It has been joined by the All-Party Pharmacy Group, which raised the subject with health minister Lord Hunt on April 25.

Chairman Dr Howard Stoate said: "These medicines are currently supplied as pharmacy-only products by pharmacists, who are the NHS's experts in medicines. As a GP myself, I am confident that pharmacists can make sensible judgements and appropriate interventions to prevent the abuse of these medicines." **TH**

Mawdsleys reveals plan

Wholesaler Mawdsleys is remaining upbeat following AstraZeneca's decision to channel orders through UniChem and AAH. In a letter to customers, the company lays out purchasing options, finance and marketing services, and technical and commercial innovations.

Mawdsleys has the capability to provide a single order point for customers, reducing any additional administration associated with the AZ distribution changes. Exactly how this will work is still to be decided.

John Davies, retail services director, said: "We will certainly survive. Mawdsleys is a robust and diverse company with a whole range of things to offer. We're strong in PIs, generics and IT. The company is well placed to react quickly to change." **LAR**

Lord Hunt hints at pharmacy service boost in contract review

Max Gosney

The Galbraith review will call on PCTs to step up commissioning of services from community pharmacy, Lord Hunt has revealed.

"It's [the Galbraith review] really consistent with the discussions we've had around making the most of community pharmacy. We believe we've found a way that gets pharmacy into the wider healthcare team," the pharmacy minister told an All-Party Pharmacy Group meeting last week.

The government's review into the provision of pharmacy contracts will deliver a blueprint for closer working between contractors and NHS authorities when it is published later this month, Lord Hunt indicated.

He said: "As a government we see the role of the profession as an important one. We want to increase the number of pharmacy led services with PCTs as principle commissioners. We are doing everything we can to get PCTs to up their game."

However, the pharmacy minister ruled out the use of national enhanced service templates in England to boost commissioning opportunities for pharmacy. "I want PCTs to be in the driving seat and make it as easy as possible for them to develop services. The last thing I want is enforced regulation."

Lord Hunt: looking for a way to get pharmacy into the wider healthcare team

Lord Hunt told the APPG inquiry into the future of pharmacy that the 2005 contract had delivered a "foundation to build on". However, the reorganisation of PCTs and funding problems had restricted uptake of enhanced services such as diabetes testing and EHC, he said.

"This has been a period of change for PCTs. We know that they have had to deal with difficulties. I'm pleased with the progress made, but more can be done.

"I am going to be paying close attention to that because it will be critical to taking the contract forward," he said.

Lord Hunt's comments completed the APPG inquiry into the future of pharmacy. MPs will publish a report of their findings this summer.

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Smoking ban opportunity

The head of the pharmaceutical society in Northern Ireland has called for pharmacists in the province to play their part in helping the public quit smoking now a ban is in place.

Raymond Anderson, president of the Pharmaceutical Society of Northern Ireland, said the ban opens the door for pharmacists to increase their role in providing advice.

"We have a regional scheme that allows customers who want to stop smoking and who don't pay for prescriptions to get NRT free," he said. "I would like to see all pharmacists participate."

Local pharmacies have boosted smoking cessation services to assist those who want to quit.

Wendy Evans, pharmacist manager at Alliance Pharmacy in Londonderry, said the chain is offering a free stop-smoking service. "All of our pharmacists are accredited and are able to provide the necessary advice and, if required, nicotine replacement services to assist with quitting." **CS**

Rules for elite pharmacist revealed by the department

The Department of Health has published guidance on the accreditation and commissioning of pharmacists with a special interest (PhwSI).

The accreditation document outlines that PhwSIs will be expected to demonstrate competencies in line with the PhwSI competency framework and any related speciality-specific guidelines. This may take the form of a portfolio of evidence including:

- appropriate education, training, development and motivation, and supervised clinical work completed
- audits and other relevant practice development undertaken.

From the point of application, the accreditation process is expected to take no longer than eight weeks and the first accredited PhwSIs are expected to emerge before the end of the year.

The new publication points out that practice-based commissioning (PBC) provides a major opportunity for practices to initiate and support the move of specialised services to more convenient locations, such as local community pharmacies.

PCTs may also wish to commission PhwSIs to a specific project, however.

Beth Taylor, national project lead, Pharmacists with Special Interests, said: "We are keen to see pharmacists take advantage of the opportunities presented by service redesign."

Launching the initiative, Implementing Care Closer to Home – Providing Convenient, Quality Care, health minister Andy Burnham said: "Practitioners with special interests have a key role to play in taking the pressure off acute hospitals and providing high quality care to patients."

The new resources are being introduced to the NHS through regional events taking place this month. Further information is available at www.pcc.nhs.uk/173.php

News in brief

NPA practice leaflets

The NPA has devised a template that enables members to develop practice leaflets that it claims save time on design and production while complying with the requirements of the new contract. Visit www.npa.co.uk or call 01727 858687 for more details.

UniChem training pack

UniChem has launched a pre-registration training programme for independent pharmacy. The pack is designed to provide a one-stop-shop for pharmacists who are hosting a pre-reg student. For further information contact Sanjay Pathak on 020 8974 4032 or email sanjay_pathak@unichem.co.uk

TV licence fine for Boots

Alliance Boots has been fined after stores in Sutton and New Malden were prosecuted for having televisions in staff areas but no licence.

The company pleaded guilty at Richmond Court and was fined £400 for each offence and £800 in costs.

Aspirin stroke risk

People who regularly take aspirin to ward off strokes in later life could be doing themselves more harm than good, particularly for people over the age of 75, according to research from the University of Oxford published in The Lancet Neurology.

New scientific advisor

Professor Jayne Lawrence has been appointed as the new chief scientific advisor for the RPSGB.

Repackaging judgement

The BAEPD has praised a judgement from the European Court of Justice that repackaging is appropriate providing the rights of trademark owners are respected. The UK Appeal Court will rule on the implications of the judgement for the UK.

PBC rates level off

Uptake of incentive payments for practice-based commissioning has levelled at 96 per cent as of the end of March, figures from the Department of Health have revealed.

In January, uptake stood at 94 per cent. GP representatives have said the figures are "as expected".

News in brief

Celesio takes stake

German company Celesio has snapped up a majority stake in DocMorris, Europe's largest mail order pharmacy, which has ambitious plans to expand its franchise network to 500 pharmacies by 2012.

NI pay awards

Health minister Paul Goggins has said that pay rises for healthcare professionals in Northern Ireland will match the rest of the NHS. Awards of more than 1.5 per cent will be staged, with 1.5 per cent paid at April 1 and the remainder paid from November 1.

Kent oncology session

Weald of Kent RPSGB branch members have been invited to a talk by Dr Beesley, consultant oncologist from Maidstone and Tunbridge Wells NHS Trust, on developments in chemotherapy on May 10.

Northants meets

RPSGB head of ethics Lynsey Cleland will give a talk on the code of ethics and controlled drugs for Northamptonshire branch members at Kettering Conference Centre on May 29 at 7.30pm.

GSK wins injunction

GSK has secured an injunction banning animal rights protestors from 18 of its sites across the UK. Campaigners have targeted the pharmaceutical firm for using research from the controversial Huntingdon Life Sciences.

Pharmacy vacancies

Recruitment consultancy New Directions has been signed up as a preferred supplier to Alliance Boots on an 18-month contract.

Campaign goes on air

Thousands of people in Northern Ireland were shown the benefits of pharmacy this week when Ulster TV aired an advert as part of the NPA's Ask Your Pharmacist campaign.

Reckitt Benckiser rises

Forecasts for Reckitt Benckiser have been raised from single figures into the mid-teens after the company built on last year's release in revenues with a 63 per cent jump in net income in the [illegible]

Pharmacy potential not exploited in asthma care

Improved primary care services could cut emergencies by 75 per cent

Tom Hawkins

Pharmacy bodies have called for contractors to play a greater role in the long-term management of asthma after a major report highlighted failings in existing patient support.

The study by Asthma UK revealed huge variations in the number of emergency admissions for asthma patients across the country. It found that 75 per cent of these were avoidable through an improvement in primary care services, such as medicines management, at a saving of £43.7 million to the NHS in England alone.

Neal Patel, spokesman for the NPA, said: "The government is keen to invest in primary care but it seems that patients aren't benefiting yet. It's taking a long time for commissioners to catch up."

Paul Gimson, lead pharmacist for long-term care at the RPSGB, urged the government and commissioners to consider evidence of the value of MURs, patient education and therapy management when addressing the issues identified in the report.

Simon Selo of Asthma UK said MURs were part of a number of initiatives the charity is backing to improve pharmacy involvement. It has produced an MUR pack and a leaflet for patients, and developed an emergency care kit to help commissioners assess their asthma care provision.

A Department of Health spokesperson said it was a government priority to move people with long-term conditions from "reactive care in hospitals to preventative, personalised care in the community".

The research, released on World Asthma Day on May 1, coincided with a study of 154 asthma patients commissioned by Lloydspharmacy, which found that 78 per cent were more confident in controlling their condition after completing a medicines review. As many as 87 per cent altered their medication regimen as a result.

Of the patients that were subsequently referred to their GP or asthma nurse, a fifth had their dosage increased or were prescribed additional medication, 12 per cent had their medication changed and 10 per cent had their dosage reduced.

Andy Murdock, pharmacy director at Lloydspharmacy, said: "The asthma MUR was one of the first we offered. It is encouraging to know that our customers are finding the service as beneficial as we had hoped."

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The Labour Party in Wales highlighted its pledge to develop new pharmacy-based NHS drop-in centres during a visit to Boots pharmacy on Queen Street in Cardiff prior to this week's local elections. Pictured (from the left) are Brian Gibbons, health minister in the last Welsh Assembly Government; first minister for Wales, Rhodri Morgan; Andy Jackson from Boots; Peter Haydn Jones, chief executive of Community Pharmacy Wales; and Marc Donovan, South Wales pharmacy manager at Boots

Merger bears fruit for Boots

Alliance Boots, which is poised to go private in an £11.1 billion deal, has posted a rise in profits in its first annual results as a merged entity.

Underlying earnings at the pharmacy group were just above analyst expectations, climbing 7.4 per cent to £641 million in the year to March 31.

Revenues rose a moderate 3.6 per cent to £14.6m, demonstrating the impact of £20m worth of savings generated through last year's £7bn merger. Costs are expected to be cut by £100m within three years.

Richard Baker, chief executive, said: "Across the group we have seen the positive impact of our pre-merger planning, new working relationships and our dedicated people all contributing to the good results."

Shareholders in Alliance Boots are to vote on the £11.39 per share offer tabled last week by KKR and deputy chairman Stefano Pessina. If it is accepted this will be the first FTSE 100 company to be privately owned. **TH**

Stop-smoking fraud

A London pharmacist has been found guilty of defrauding the NHS out of money earmarked for smoking cessation schemes and fined £3,000.

Anil Shah, of Dearcare Pharmacy in Richmond Way, was accredited to provide stop-smoking programmes by Hammersmith & Fulham PCT.

The trust alerted the NHS Counter Fraud Service after it became suspicious. An investigation subsequently revealed that Mr Shah had falsified claims over the number of treatments he provided and the number of patients completing the programme.

Mr Shah pleaded not guilty to four counts of false accounting at Blackfriars Crown Court. He was found guilty by a jury on three counts and the fourth will remain on file. As well as the £3,000 fine, he was ordered to pay costs of £1,500.

Judge Egam, who presided over the case, described Mr Shah's actions as "a serious breach of trust". **TH**

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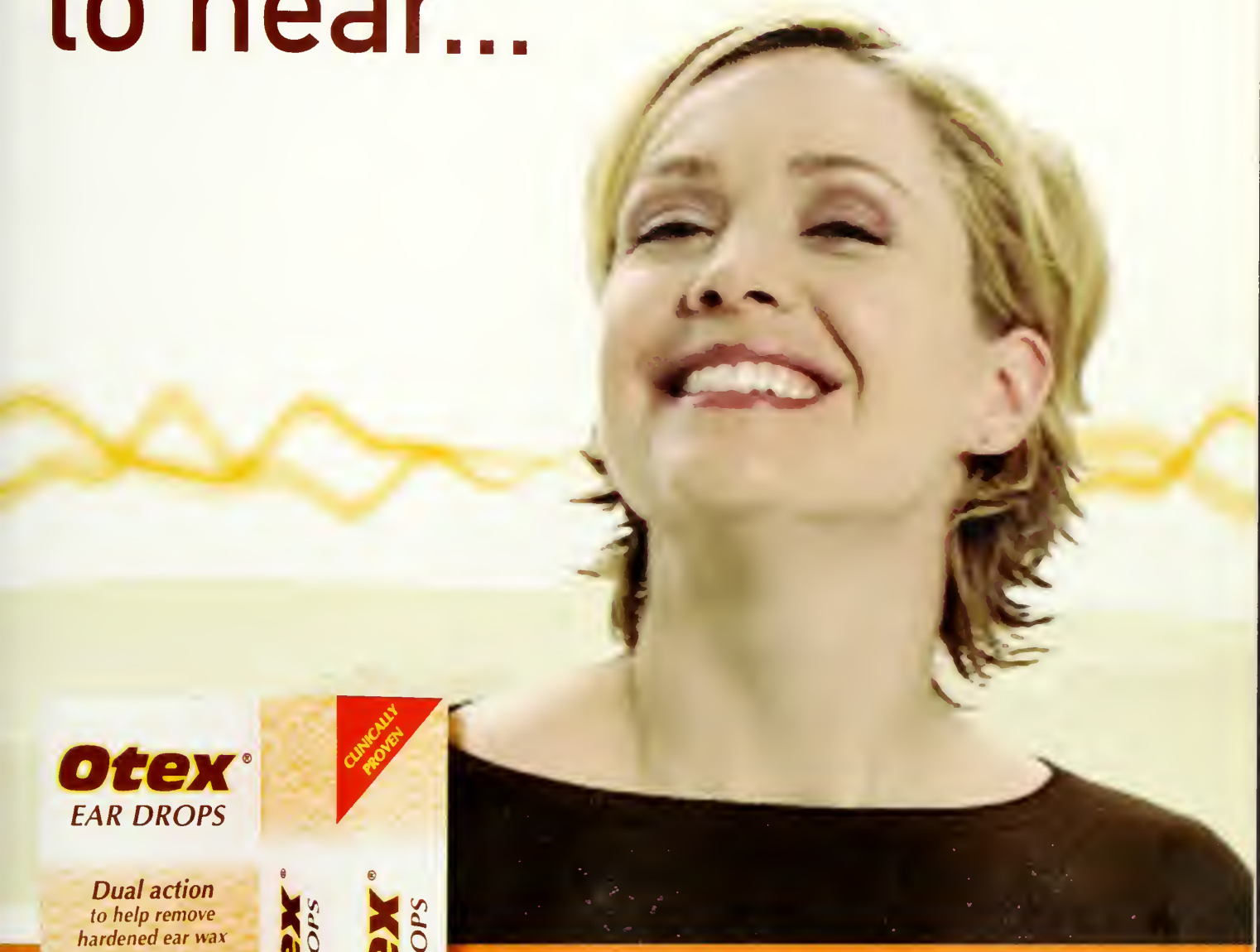

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News in brief

NHS complaints rise

Complaints to NHS Direct have risen by 50 per cent since the end of 2006. The 24-hour helpline received 1.89 complaints per 10,000 calls in March this year.

Historic society meeting

Dr Nicholas Cambridge of the Wellcome Trust Centre for the History of Medicine at University College London is holding a meeting entitled Electricity and Enlightenment on May 9 at 6.30pm at the RPSGB in Lambeth.

Faulty equipment plea

The Medicines and Healthcare products Regulatory Agency (MHRA) is asking healthcare professionals to report faulty or deficient medical equipment to help prevent 1,500 incidents of serious injury or death every year.

Internet trader jailed

Martin Simon Hickman of Ashton-Under-Lyne was sentenced to three months' imprisonment and his company, MSH World Traders Ltd, was fined £20,000 for contempt after he failed to cease advertising medicinal products, including Viagra and the unlicensed drug Kamagra, on the internet.

Job leaflet targets teens

RPSGB has launched a careers leaflet and updated its website www.pharmacycareers.org.uk in an effort to broaden the appeal of a career in pharmacy to people aged between 13 and 17 years.

Boots in carbon promise

Alliance Boots sponsored this week's May Day Summit on climate change hosted by the Prince of Wales. More than 1,200 businesses pledged their commitment to move towards a low carbon economy.

MHRA monitors PILs

The Commission on Human Medicines Expert Advisory Group on Patient Information has developed a work plan to monitor progress in the improvement of patient information leaflets (PILs). www.mhra.gov.uk

Alliance allays concerns

NHS Alliance has advised the NHS Appointments Commission on the process of appointing non-executive directors to PCTs to ease tensions that arose following last year's reconfiguration of trusts

Pharmacy makes its case for the record

Six reasons why pharmacists should have electronic patient record access

Ailsa Colquhoun

Pharmacy representatives have outlined six reasons why community pharmacists should have access to the electronic patient record.

In a written submission to the Health Select Committee inquiry into the Care Record Service, groups including the Association of Independent Multiple pharmacies, the Company Chemists' Association, the NPA and PSNC this week called for pharmacists to be involved in the implementation of the CRS at an early stage.

They believe this will:

- improve patient safety
- encourage new pharmacy services
- ensure continuity of patient care
- help interdisciplinary working
- provide a primary and secondary care interface
- limit incidences of violence against NHS staff and contractors.

The evidence was submitted in the first of a series of Health Select Committee meetings on April 26. At the session, MPs, GPs, patients and IT specialists demanded to know why the CRS comprises separate summary and detailed care records, why it is running late and why users have not been consulted on the service. They also suggested patients did not fully understand the aims of the service.

In a robust defence of the programme, director-general of NHS IT Richard Granger reiterated that the summary record fulfilled an important "emergency" function and that, in fact, the difficulty of gaining consensus between clinicians was one of the reasons why the CRS was now behind schedule. He added that concerns over confidentiality had been over-exaggerated.

- The National Audit Office is to carry out a second review of the NHS IT programme, to check the government's compliance with the recommendations of the first report (C+D, April 28, p8).

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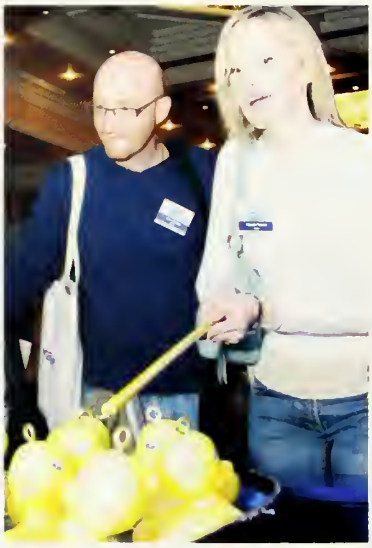
All the fun of the fair

Staff from more than 400 Co-operative Group pharmacies chanced their arm on the coconut shy and got stuck into plenty of candyfloss during the annual conference and awards at the National Motorcycle Museum last week. David Wildman of Great Oakley won pharmacist of the year; the Pentwyn branch, Cardiff, won best customer services; and 'best transformation' among rebranded outlets went to the Hunslet, Leeds, branch. Awards also went to Scott Leiper, Amanda Milsted and Natalie McKelvey. **CS**



Duck to water: Mark Nathan, pharmacist at Highgate in north London, and support manager Michelle Tomas get into the spirit

'Rosy' government reviews under fire

The British Heart Foundation and mental health charity Mind have criticised "over-optimistic" and "rosy" Department of Health reviews of the government's record on tackling heart disease and managing mental health.

The reviews, by heart disease and stroke and mental health Tsars Professors Roger Boyle and Louis Appleby, listed achievements and initiatives in each area in the last decade under the Labour government.

Professor Boyle estimated that 3.4 million people are now taking statins, and that the number of prescriptions was rising 30 per cent year on year.

Professor Appleby reported that schizophrenia treatment had improved through the availability of modern atypical anti-psychotics.

However, BHF director of prevention and care Dr Mike Knapton said that in trying to establish his health legacy Tony Blair was "painting an over-optimistic picture of a job done". Mind chief executive Paul Farmer said the picture in mental health was "not as rosy as the government would have you believe".

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Pharmacists to sign up CMS patients

Scottish pharmacists have welcomed government promises of security for the forthcoming chronic medication service.

Speaking at the Pharmacy Practitioner Champions day held in Edinburgh, Scottish Executive chief pharmaceutical officer Bill Scott told pharmacists that the CMS will be based on a capitation payment, and that pharmacists will retain the ability to 'sign up' patients who are clinically suitable for the scheme.

According to Berwickshire contractor George Romanes: "This means we are not dependent on the doctors playing ball."

The SEHD also told the pharmacy practitioner champions that pharmacists could carry over their minor ailment scheme capitation levels (as of March 31, 2007) into this financial year, for use as a minimum payment level. It has also advised that MAS will be the theme of the first public health scheme window display, scheduled to take place in July, and that MAS will be further publicised in a new information leaflet.

Mr Romanes added: "There was a strong feeling of optimism that we have a reasonable degree of financial security, for the start of the e-acute medication service. This is still being seen as achievable for the second half of the year." **AC**

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- **Favourable safety and tolerability profile in approximately 4,000 treated smokers**[6]

†Based on the Minnesota Nicotine Withdrawal Scale and Questionnaire of Smoking Urges

CHAMPIX® Film-Coated Tablets (varenicline tartrate) ABBREVIATED PRESCRIBING INFORMATION - UK. Please refer to the SmPC before prescribing Champix 0.5 mg and 1 mg. **Presentation:** White, capsular-shaped, biconvex tablets debossed with "*Pfizer*" on one side and "CHX 0.5" on the other side and light blue, capsular-shaped, biconvex tablets debossed with "*Pfizer*" on one side and "CHX 1.0" on the other side. **Indications:** Champix is indicated for smoking cessation in adults. **Oosage:** The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1-3: 0.5 mg once daily, Oays 4-7: 0.5 mg twice daily and Oay 8-End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should start 1-2 weeks before this date. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with Champix for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. **Patients with renal insufficiency:** *Mild to moderate renal impairment*: No dosage adjustment is necessary. *Patients with moderate renal impairment who experience intolerable adverse events*: Oosing may be reduced to 1 mg once daily. *Severe renal impairment*: 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. *Patients with end stage renal disease*: Treatment is not recommended. **Patients with hepatic impairment and elderly patients:** No dosage adjustment is necessary. **Paediatric patients:** Not recommended in patients below the age of 18 years. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** Effect of smoking cessation: Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Smoking cessation may result in an increase of plasma levels of CYP1A2 substrates. Smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. **Pregnancy and lactation:** Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Champix should only be prescribed to breast feeding mothers when the benefit outweighs the risk. **Driving and operating machinery:** Champix may have minor or moderate influence on the ability to drive and use machines. Champix may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. **Side effects:** Adverse reactions during clinical trials were usually mild to moderate. Most commonly reported side effects were abnormal dreams, insomnia, headache and nausea. Commonly reported side effects were increased appetite, somnolence, dizziness, dysgeusis, vomiting, constipation, diarrhoea, abdominal distension, stomach discomfort, dyspepsia, flatulence dry mouth and fatigue. See SmPC for less commonly reported side effects. **Overdose:** Standard supportive measures to be adopted as required. Varenicline has been shown to be dialyzed in patients with end stage renal disease, however, there is no experience in dialysis following overdose. **Legal category:** POM. **Basic NHS cost:** Pack of 25 11 x 0.5 mg and 14 x 1 mg tablets Card (EU/1/06/360/003) £27.30, Pack of 28 1 mg tablets Card (EU/1/06/360/004) £27.30, Pack of 56 0.5 mg tablets HDPE Bottle (EU/1/06/360/001) £54.60, Pack of 56 1 mg tablets HOPE Bottle (EU/1/06/360/002) £54.60, Pack of 56 1 mg tablets Card (EU/1/06/360/005) £54.60. Not all pack sizes may be marketed / marketed at launch. **Marketing Authorisation Holder:** Pfizer Limited, Sandwich, Kent, CT13 9NJ, United Kingdom. **Further information on request:** Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS. Last revised: 09/2006

Adverse events should be reported to Pfizer Medical Information on 01304 616161. Information about adverse event reporting can also be found at www.yellowcard.gov.uk

References: 1. Gonzales D *et al.* JAMA 2006; 296:47-55. **2.** Jorenby DE *et al.* JAMA 2006; 296:56-63. **3.** Tonstad S *et al.* JAMA 2006; 296:64-71. **4.** Coe JW. J Med Chem 2005; 48:3474-3477. **5.** Gonzales DH *et al.* Presented at 12th SRNT, 15-18th Feb, 2006, Orlando, Florida. Abstract PA9-2. **6.** CHAMPIX Summary of Product Characteristics.

CHA055a Date of preparation: Nov 2006

Pfizer

New oral prescription medicine

CHAMPIX

varenicline tartrate

Your letters

A Practical Approach: trimethoprim and resistance

I follow the scenarios in David Spencer's Update Pharmacy with great interest, but have reservations about the line of action suggested in C+D, April 14, p28 when a GP wanted the pharmacist to supply trimethoprim for patients with cystitis by patient group direction.

In fairness, the GP wanted to reduce his consultations for patients with a common, usually minor, illness in women that he thought the pharmacist could deal with equally effectively. Wonderful idea – and a great opportunity for a collaborative venture. However, although good in principle, this proposal falls down in the detail.

Some hospital microbiologists are reporting a rising resistance of urinary coliforms to trimethoprim in samples from patients in primary care and currently this resistance stands at about 30 per cent.

This calls into question the efficacy of this agent as first-line empirical treatment, and makes one wonder whether an increase in its availability, in the circumstances suggested here, might render it practically useless.

There are parallels with amoxicillin, which at one time was the first-line empirical choice for the management of urinary tract infections (UTIs).

The MHRA's consultation document on the proposal to

reclassify trimethoprim as a P medicine acknowledged that increased antibiotic usage may contribute to increased resistance and it may be the case that the high levels of resistance seen with trimethoprim are caused by its inappropriate use by GPs. The fact that 50 per cent of patients' urine samples have negative cultures also raises the question of whether all cases should be treated with an antibiotic.

GPs are being encouraged to reduce their prescribing of antibiotics by the government so that resistance to these agents can be checked. I think the GP in this scenario would have benefited from more circumspect advice and hopefully that would have been provided by the prescribing adviser when David Spencer discussed the idea with his PCT.

The increasing levels of resistance to trimethoprim may be one of the reasons that the MHRA has not approved this drug's reclassification as a P medicine since it invited comments on the proposal to do so over 18 months ago.

It certainly is the reason why some PCT advisers and microbiologists alike are recommending GPs to prescribe other antibiotics as first-line empirical treatment of UTIs.

Incidentally, the idea of a pharmacist supplying the drug through a patient group directive and then obtaining a prescription from the GP is not viable.

David Spencer requires some advice about this idea and needs some extra backup to prevent him from taking inappropriate action.

Until recently I was a PCT prescribing adviser, but have now retired from the post, and was for most of my career a lecturer in clinical pharmacy.

Clive Edwards PhD, MPharmS

Alan Nathan BA, FRPharmS, the author of our Practical Approach series, replies:

Poor old David Spencer is just a humble community pharmacist and not a PCT prescribing adviser or former lecturer in clinical pharmacology. He takes the BNF as his authority, which states (in two places, sections 5.1 and 5.13), as treatment for 'lower' urinary tract infection: "Trimethoprim... treat for seven days but a short course (eg three days) is usually adequate for uncomplicated urinary tract infections in women."

College vote clarification

Hemant Patel: talk of June vote is premature

Your story entitled "Royal college: June vote?" (C+D, April 28, p6) may confuse some readers, suggesting as it does that Society members may get a vote on a royal college in the next few months.

When I spoke to C+D I said – and you quoted – "I doubt a vote will run before June or July". Earlier in the same article I was quoted as saying that "a ballot without a proper discussion is not on the agenda".

The Society has embarked on an active programme to gather the views of members including speaking at branch meetings; a special section on our website where we plan to post a short questionnaire; regular email alerts to the 20,000-plus members who have signed up to the 'myRPSGB' section of our website; and regular press briefings by me as president of the Society.

Any talk of a membership vote in June is premature and we need to seek the views of the membership about a royal college before such a vote could be considered.

Hemant Patel
president, RPSGB

Mawdsleys responds to market changes

Your editorial of April 28 (C+D, p14) quite rightly suggests that Mawdsleys should react quickly to the changing situation in the wholesale market. Rather contrary to your view, Mawdsleys' freedom from any European or retail ties allows us far greater flexibility and speed of response to change than any other wholesaler.

While Mawdsleys has campaigned vigorously against the dangerously ill-considered plans put forward by Pfizer and others, it has been evident to us for some years that fundamental market changes affecting all wholesalers were almost inevitable. The Mawdsleys group has been structured with exactly that in mind and now provides products and services to a wide range of pharmaceutical markets as well as wholesaling to community pharmacy, which remains a key part of our business.

We regret that AstraZeneca has chosen to exclude ourselves and others from its distribution scheme and would clearly welcome the opportunity of re-opening negotiations with it.

In the meantime our business philosophy is unchanged and our commitment to our community pharmacy customers remains as strong as ever. We will continue to work closely with them to provide innovative and profitable services designed to sustain independent community pharmacy through the demanding future it now faces.

Ian Brownlee
managing director
Mawdsleys

Ian Brownlee: Mawdsleys is prepared for the changes

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Your letters

Royal College of Pharmacists by pharmacists, for pharmacists

Creating a Royal College of pharmacists, by pharmacists, for pharmacists is crucial, now that the government has decided to remove regulation from the RPSGB. Widespread discussion and a full debate must occur in order to create a vision for a Royal College of Pharmacists that the vast majority of the profession can sign up to.

The Association of Pharmacy Technicians UK (APTUK) tells us it wants the royal college to be "inclusive", meaning that pharmacy technicians become full members. Thoughts such as 'not a hope' and 'not on my watch' come to mind. I am sure that the majority of pharmacists will agree once they understand the possible consequences of allowing technicians to become full members.

The Privy Council (www.privy-council.org.uk/output/page45.asp) lays down specific academic requirements for members of a chartered body. A national vocational qualification simply does not satisfy this criterion. Allowing technicians to be members will jeopardise the chartered status and creation of our proposed royal college.

Mark Walker: allowing technicians to join would jeopardise charter status

APTUK is the recognised professional representative organisation for pharmacy technicians, in all sectors of the profession, throughout the UK. One of its founding principles is 'run by pharmacy technicians, for pharmacy technicians'. Why would pharmacists allow this organisation, affiliated to a trade union, to muscle in on our professional body? After all, we agree that our royal college will never be a trade union. Of course, there should be co-operation between APTUK and the royal college but only on the basis that APTUK is representative of all branches of pharmacy; that it seeks patient input and acknowledges the separate role of the Society/royal college.

There are clear conflicts of interest that mean technicians must continue to have their own representative body. For example, the current debate around remote supervision and skill mix. I believe that the majority of the profession would find the prospect of allowing a community pharmacy to operate for more than a few minutes without a pharmacist present to be unsafe and unacceptable. I hope that our professional body will be our vocal advocate and say this is unsafe and therefore professionally unacceptable. This is likely to be in opposition to APTUK, which is an ambitious voice for technicians.

Council, please stop any discussions regarding full technician membership of our proposed royal college. Instead, work with ordinary members to create a vision for a Royal College of Pharmacists, by pharmacists, for pharmacists.

Mark Walker MRPharmS, Oxford

Sarah Wilcox, president of the Association of Pharmacy Technicians UK, responds:

The world is a changing place and this is no different in pharmacy, however, change is not always bad. Pharmacists and pharmacy technicians have been working in partnership for many years and will continue to do so. The current situation offers opportunities to strengthen that link. What APTUK believes is that pharmacy technicians have a valuable and important part to play in providing a pharmacy service, indeed, delivery of the strategic agenda for clinical pharmacy relies on them!

APTUK understands that patients, the public and other healthcare professionals need to differentiate between the qualifications and skills of differing grades of pharmacy staff. APTUK has not used the term 'full membership' in any of its correspondence on this matter, membership categories are something that will need to be debated and decided.

The growth in extended roles for pharmacy technicians will not stand still and there are already discussions around the suitability of the current training standards for pharmacy technicians. This is bound to drive up the academic entry levels and the overall standard of training, possibly to graduate level!

The case for pharmacy technician membership of a royal college has been developed by APTUK and is being distributed to an appropriate audience for debate and decisions.

The future membership of the royal college will depend on calm, rational debate, logical arguments and decisions based on the willingness of the pharmacy profession to work in partnership. Decisions will be made by key stakeholders in strategic forums, not in the pages of the pharmaceutical press.

Anticoagulation issue must be addressed

We were pleased to read that Xrayser recognised the benefit of the work carried out by the National Patient Safety Agency (NPSA) in relation to anticoagulation therapy, and agrees that the safety issues associated with this therapy need to be addressed (C+D, April 14, p15).

It has always been the responsibility of the pharmacist to help ensure that dispensed medicines are used safely by patients. In the case of oral anticoagulants, unlike other medicines that are dispensed, there is usually no dose included on the prescription to check. It has been assumed by pharmacists that there was no requirement to check that the patient was receiving regular blood tests and that the dose being taken was safe. The NPSA has found that some patients do not go to their anticoagulant clinic for blood tests, and may be confused and taking the wrong dose of anticoagulant.

[illegible] is recommending to all [illegible] including GPs, [illegible] and hospital [illegible] they check this [illegible] with the patient when [illegible] prescriptions are requested [illegible] ed. In the new patient-held anticoagulant information booklet (yellow book) patients are being encouraged to present their INR results to their GP and pharmacist. This process is not the same – or as lengthy – as a full medicines use review, but may lead to such a review if problems with the dosage and monitoring of anticoagulants are found that may indicate there are similar problems with other medicines the patient is taking.

Although these checks with anticoagulants may take a little more time, we would suggest that there is no more appropriate use of pharmacists' time than making sure patients are kept safe.

The vast majority of patients will be found to be attending a clinic, having regular blood tests and taking safe doses of anticoagulants and will not require further intervention from the pharmacist.

However, occasionally the pharmacist could find a patient with a serious problem and the pharmacist's intervention could literally be life saving to that patient. We would have thought that community pharmacists [illegible] have welcomed a more clinical [illegible] makes best use of their skills and raises their clinical profile among their patients.

The NPSA is not recommending patients should be denied therapy if the INR blood test result is not available, simply that steps are taken as soon as possible to confirm that the anticoagulant therapy dispensed is safe for the patient. This information can easily be provided on the telephone to the pharmacist.

IT solutions may well form part of future system changes although these are unlikely to be available in the short-term. In the meantime, we need to find ways of preventing patient harms from anticoagulants and we would suggest that the advice issued by the NPSA goes some way to achieving this. Access to patient records is indeed what the NPSA is advocating in the form of the patient-held INR result sheet.

Rather than referring to community pharmacists as "INR policemen" we see them as "patient advocates" with a key clinical role to play in keeping patients safe.

David Cousins, head of safe medication practice
Bruce Warner, senior pharmacist
National Patient Safety Agency

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new

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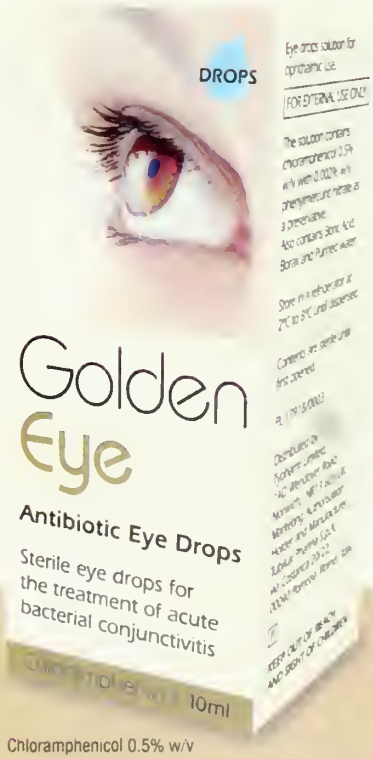

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Comment from the editor

Lord Hunt's bullish comments must not go to waste

The haste with which the latest Department of Health review into control of entry has been conducted questions the notion that the government machinery is a slow unwieldy beast.

Launching the review earlier this year, health minister Andy Burnham talked about giving PCTs more power to commission, and maximising choice and contestability. If there was a better way to deliver pharmacy services in a modern reformed NHS, the latest review would show us how, we were told.

So the few clues that Lord Hunt, Andy Burnham's replacement as minister for pharmacy, gave at last week's All-Party Pharmacy Group meeting are worth a second look.

His comment that the DH had "found a way that gets pharmacy into the wider healthcare team" is a welcome start. As was his remark about getting PCTs to "up their game" when it comes to commissioning pharmacy services.

So can we take it from the minister's comments that the future is rosy for community pharmacy? And will PCTs, having realised the error of their ways, make every effort to maximise the input of pharmacists and their staff? Or will the latest review be just another document that highlights how effective and efficient community pharmacy services can be but then fails to deliver any tangible action?

Lord Hunt's comments come as the DH revealed how pharmacists with a special interest will be accredited and commissioned. This is another boost for community pharmacy, especially as combining the new role with independent prescribing offers a powerful commissioning opportunity for local paymasters.

But if such opportunities are not to be wasted, a national implementation plan needs first to be agreed and then made to happen. History shows, on the whole, that community pharmacists still do not figure highly on the radar of local commissioners – just look at the patchy commissioning of enhanced services.

With contractors only just getting over the upheaval caused by the contract and control of entry changes, community pharmacists will be eyeing the outcome of the government's latest review with some trepidation. Change for change's sake is never welcome, and we can only hope that Lord Hunt's bullish comments are backed by a concrete commitment to commission and fund healthcare solutions from the country's most accessible healthcare providers.

> On the whole, community pharmacists do not figure highly on the radar of local commissioners

Your views

Get one step ahead of the smoking ban

With the smoking ban in mind, businesses are an ideal target for the proactive pharmacist, says Miriam Armstrong

So much has been written recently about the imminent smoking ban in virtually all enclosed places and workplaces in England that we could almost be tempted to switch off, [illegible] publicity fatigue. But this could be a huge mistake, as the legislation [illegible] great opportunity for [illegible] pharmacy [illegible] overdue ban in England from July 1 will mean that the whole of the UK will be smoke-free, which is great news for anyone who has an interest in public health. Smoking has been known to be the main cause of many avoidable diseases, especially lung cancer and heart problems, for more than 50 years and yet it has taken respective governments this long to introduce legislation. But at last they have, so let's be grateful and use it to our advantage.

Community pharmacists will now not only have a great reason to lobby their customers and patients to help them to stop smoking but it will also give them the opportunity to spread their expertise wider by offering local companies – including restaurants and pubs – advice on nicotine replacement therapies and other support for their employees.

Many pharmacists have told PHLink that they are not waiting for their PCTs to contact them with possible avenues of funding and have already started targeting local companies on a proactive basis, to suggest how they can help. And local companies are keen for this support – as under Nice's workplace interventions to promote smoking cessation guide, they are now obliged to help employees to stop smoking. And although this obligation isn't legally binding, employers who do provide smoking cessation support will be reducing their risk of non-compliance with the law. This is especially pertinent where employers provide vehicles for deliveries or their businesses involve sales team vehicles, as the no-smoking ban will include all vehicles used for business, as well as any rooms or shelters that were previously set aside for smokers.

Councils will be doing their bit too. They recognise that the introduction of this legislation will mean a cultural change for many businesses and will be running local publicity campaigns concurrently with the national publicity aimed at encouraging smokers to stop. Councils will need their local pharmacists to step in and help.

And by now all community pharmacists in England will have received the public health cards and public information leaflets mailed from the Department of Health. This mailing included a set of health issue cards, 25 public information leaflets and a background guidance leaflet for pharmacists and their staff. The health cards cover the top five priority public health areas, including stopping smoking, and have been produced to help pharmacists and their staff give brief advice to patients.

The cards detail how to ask direct or indirect questions to establish the person's interest in stopping smoking and give advice on how best to stop in a detailed 'Top Tips' section. The leaflet supports any discussion and can be given to the patient to take away.

All the resources can be found on the supporting website – www.pharmacymeetspublichealth.org

Miriam Armstrong is chief executive of PharmacyHealthLink

Xrayser

Silly restrictions encourage silly behaviour

As all sensible argument in the 'Stop the Switch' campaign says, changing the legal classification of pseudoephedrine isn't likely to make much difference to illicit use of any drug in this country. And with illegal drug use generally falling of its own accord anyway (C+D, April 28, p8) perhaps the tide is finally turning against drug abuse.

The prevalence of drug use is due to a wide-ranging and complex mixture of socio-economic and cultural factors, and very little to do with their legal classification. This is why I don't believe that a significantly greater amount of cannabis or heroin would be consumed if it were legal.

A few prescriptions I've dispensed recently for Sativex, the cannabis-based oromucosal spray, made me think that the whole system is rather whimsical anyway. This drug seems to have fallen through a number of loopholes in the system.

Sativex is listed in Schedule 1 of the Misuse of Drugs Act, which puts it up there with all the baddest drugs known to man. Yet since the Home Office lifted some of the restrictions on its use, it can be prescribed by any GP and I don't need to record dispensings in the CD register.

Prescriptions need to comply with CD regs and I need to keep any stock in a lockable fridge. As I don't have one of those, I have to hide my regular fridge where no robber can see it.

It seems strange that when the product is granted a licence it will be rescheduled as a Schedule 4 controlled drug. Will that mean that I can take the fridge back out of the stock room?

The point is that, whatever restrictions are placed on this drug they only ever create extra work for me and the GP, and a delay for patients who need treatment. It makes no difference whatsoever whether dispensings are recorded in the register or whether patients can see my fridge or not.

Surely in this case, as with pseudoephedrine, it is time for common sense to prevail. This is all about dealing with people and being responsible professionals – two matters in which we are experts. Fewer daft rules and restrictions would give us more time to do our job properly.

These foolish things

Sometimes it's the smallest things that make me happy. Like when a local surgery finally started prescribing perindopril in 30s instead of 28s. Or when a patient returns to say 'thank you' after I gave them some advice that really made a difference.

But grander events are good too. Like when one of my staff passes an exam or makes a genuinely life-saving intervention. And the other day, a GP even praised the service from my pharmacy.

I get so fed up with moaning sometimes that even a day free of shoplifters, angry customers and dispensing errors is cause for celebration. But deep down I wouldn't be anywhere else.

My neatly arranged dispensary shelves, challenging patient interactions, excellent all-round service and clinical skills all give me so much satisfaction that I get a little big headed sometimes.

An elderly patient put me in my place last week when he asked: "If you know so much about drugs how come you're driving round in that old heap and those drug dealers have got a new BMW?"

Northern Ireland Notebook

A new way

Well, it's all over now. PSNI will soon be no more and frankly, no matter what the conservatives in our profession say, it is for the best.

The regulations currently being put together in London will create a General Pharmaceutical Council, which will comply with government wishes for what a professional regulator should be. This Council will eventually be applied to pharmacy in Northern Ireland. It is fanciful to imagine that Northern Ireland, given our size and our importance in the greater scheme of things, should merit an exception to a UK solution.

That the Unionist Party has taken the health portfolio in the devolved administration adds further support to a UK solution for pharmacy regulation. As our surreal administration pulls itself together to fight the business of government, I can only guess any aspiration of pharmacy keeping a body that is both a regulatory and a leadership organisation has been fully dashed. There are too many more urgent issues on the Stormont agenda.

Across the pond a Royal College of Pharmacy seems to be emerging as the front-runner as a professional leadership organisation to replace the Society. Government is refusing

> There are a staggering 108 bodies with a special interest in some aspect of the profession

to let this body become a trade union, which rules out an NPA/PSNC merger. Rather, a merger of the diverse interest groups that represent our evolving profession seems a likely basis for a body, has merit and should be pursued. A staggering 108 bodies with a special interest in some aspect of the profession of pharmacy exist. That there are so many is surely proof the RPSGB failed to provide the necessary leadership for the profession, as PSNI has similarly failed.

So where now for pharmacy in Northern Ireland? The best thing is to go with the flow. I look forward to joining the Royal College and perhaps one of its special interest faculties so I can be annotated as a prescribing pharmacist or a pharmacist with a special interest in diabetes, CHD or public health.

Written by a pharmacist practising in Northern Ireland

Pharmacy Champions

Pharmacists leading the way

Name
Kay Crockatt

Pharmacy
Co-op Pharmacy, Hartlepool

What has she done?
Set up a seven-day service for the supervision of methadone

What have you set up?
We have created an area in the pharmacy specifically to handle the dispensing and provision of all pharmaceutical services to clients with addictions.

The seven-day service started as a six-month pilot, working with the PCT and the Addictive Behaviour Service (ABS) locally. The Co-op arranged for us to liaise with the PCT so that we could work together to put the service in place.

The aim was to improve access to supervised methadone and buprenorphine for clients who needed more supervision than the current six-day provision. After the initial six months it was extended for a further four months and then continued through for a full year.

What has been the high and low point of setting up the service?
The highs include the positive reactions of the ABS teams, police, PCT representatives and other pharmacists in the town who have visited our specialist area. Their comments have helped us develop the service and improve its effectiveness. The greatest lift is when we see 'trouble' clients achieving non-supervised prescriptions and when there is a visible difference in their appearance and attitude. It means such a lot to all the staff involved.

The low point, however, is when the lives of the clients are reclaimed by their addictions and they return to us.

What has been the reaction of GPs, patients and other health professionals?
It's been positive. We keep in close contact with the prescribers at the clinic and there is a two-way sharing of information.

The clients ask us about other issues and support. We provide counselling and if they bring all their prescriptions to us we will talk to them about how the medicines interact. Initially we thought we would only get clients who were forced to come to us, but some have been with us since the service started, which reflects their loyalty. We ask them for their views through questionnaires and provide them with leaflets and stock the toiletries that they want. We have become a one-stop shop for all their needs.

I'm the lead pharmacist and supervise the service. There are 15 staff and everyone is involved. They enjoy the contact with the patients and build up relationships with them.

Do you have any advice for others?
Build up your service gradually. Talk to as many users and potential users as you can so you can get a feel for their needs. In a multi-disciplinary service it's important to keep the lines of communication open between everyone at all times. Remember to keep reviewing and changing the service as you find problems and improvements, and as the client numbers increase.

Why do you think you have been successful?
Because we keep in close contact with all the teams involved in providing services for addictive behaviour. The consultation area is welcoming, fresh and offers a friendly, approachable and efficient delivery of prescriptions to those who access the service.

Has offering the service given you greater job satisfaction?
The changes that you can see in clients when they begin to take charge of their lives again is so rewarding. The new area gives plenty of opportunity for direct communication in a pleasant and unhurried atmosphere. This has allowed me to form a relationship with the clients, which I hope makes a contribution to their recovery.

What are your hobbies and interests outside work?
I'm involved with the local church and I like music, reading and entertainment.

If you were in charge of the pharmacy profession for one day, what would you change?
I'd make sure we redouble our efforts to get across to the public the expert knowledge and professional services that pharmacists offer. There is no-one else quite like us on the high street and in my opinion we can never do enough to broadcast this key message.

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The MHRA wants to make pseudoephedrine prescription-only. But is there a more appropriate way to protect the public? **Emma Wilkinson** asks the experts

Crystal maze

MHRA proposals to reclassify medicines containing pseudoephedrine or ephedrine to prescription-only have caused a storm among pharmacists.

As precursors needed in the manufacture of methylamphetamine, users can use them to 'cook up' the class A drug in home laboratories. Some countries, such as the USA, Australia and New Zealand, have experienced large-scale problems with methylamphetamine abuse. But to date, the drug is barely registering on the radar in the UK and only a handful of meth labs have been found by the police.

So are the MHRA proposals a gross over-reaction that would prevent millions of cold-sufferers being able to treat their illness, or a sensible precaution against use of an illegal drug known to cause severe harm to the user and society? And what are the alternatives?

Interestingly, other countries with widespread methylamphetamine abuse have placed restrictions on OTC pseudoephedrine, some of which already exist in the UK, but have stopped short of making them prescription-only.

In most US states, retailers are required to put pseudoephedrine products behind the counter or in locked cupboards, restrict sales to 3.6g per customer (60 x 60mg tablets) and keep records of supply.

In Australia, all pseudoephedrine medicines are restricted to pharmacy sale and pack sizes are limited; similar restrictions apply in New Zealand.

However, the MHRA warns misuse of pseudoephedrine-containing products is a risk to public health both in terms of the harmful effects of methylamphetamine and from toxic and flammable byproducts of its production.

The government is "committed to taking preventative action to stop methylamphetamine misuse securing a foothold in the UK", it states.

According to the consultation document, conditions in the UK are ripe for misuse of the drug to grow. But Sheila Kelly, PAGB executive director, says methylamphetamine abuse in the UK isn't a problem that needs addressing. "Reacting when it may never become a problem doesn't seem sensible. They're trying to stop someone going from shop to shop buying a packet at a time but you're not going to stop someone having access to pseudoephedrine – you can get it from the doctor or off the internet."

She adds: "We hope the outcome of the consultation will be that we all agree we need to take this seriously but let's introduce measures in a stepwise fashion – reducing pack sizes, making it illegal to sell more than a pack."

The PAGB also points out that sales of pseudoephedrine can easily be monitored by postcode so wholesalers can spot if there's been an increase.

The National Pharmacy Association agrees that the proposals go too far. In evidence submitted to an all-party parliamentary group inquiry last week, it said the MHRA proposals were disproportionate and possibly counter-productive.

It argues that even with wide availability of pseudoephedrine in the USA, only 10 per cent of illicit methylamphetamine was produced from OTC medicines and, of this, the majority was acquired by theft.

Switching the classification to prescription-only would severely restrict consumer access to safe, effective medicines and put added pressure on GPs and NHS costs, the NPA told the inquiry.

Miriam Armstrong, chief executive officer of Pharmacyhealthlink, says the MHRA proposals had undoubtedly hit a raw nerve with pharmacists.

"If the reclassification goes ahead it will have a direct impact on 103 licensed products containing pseudoephedrine and 32 containing ephedrine.

"The majority of these are cough/cold remedies available as P medicines that have been safely and effectively used for years."

But she adds that we should be worried about the growth of illicit domestic laboratories in the UK. "Perhaps as a profession pharmacists should have acknowledged that there was a potential problem and reinforced the existing measures to demonstrate that the supervision was robust enough to protect public health."

So what would be a robust response from pharmacists? The Company Chemists' Association hopes to use the experience of colleagues in the USA to come up with an alternative strategy.

LearnSomething, a multimedia training organisation based in Florida, initially worked with the Canadian Non-Prescription Drug Manufacturers Association to raise awareness among pharmacists as a 'pre-emptive strike' against OTC products being reclassified. They developed a Methwatch programme, which was subsequently taken up by some US states. When the Combat Methamphetamine Epidemic Act in the USA set a federal minimum requirement that employers provide training for pharmacy staff and certify training with the Drug Enforcement Agency, the mechanism was already in place.

CCA chief executive Rob Darracott said: "Meth misuse is a serious problem. But we must not forget law-abiding medicine users who value these products highly will bear the burden of this change.

"Pharmacy's response must be robust. The CCA will be instrumental in leading the development of a package of non-statutory interventions that will increase pharmacists' vigilance of domestic meth production and misuse, and enable the profession, together with law enforcement agencies, to ensure the public is protected from this horrible drug."

What do pharmacists think?

Ketan Patel, Leicester:
"We're used to supplying products for which there is the potential for harm. We have guidelines on codeine linctus and opiate-based medicines. Having a P status is sufficient and I think they have gone over the top."

Ian Strachan, Widnes, Cheshire:
"It's a very narrow minded view and it's completely unnecessary. It takes away people's human right to choice and there's no evidence to suggest pharmacists can't deal with the supply of it."

Bob Dunkley, Leeds:
"There needs to be a way of controlling it. The synthesis is so easy it could become the next public health disaster. It has a greater facility than amphetamine for causing psychiatric illness and we should take a proactive view."

To join the debate and to sign the petition visit www.dotpharmacy.com/stoptheswitch

STOP THE SWITCH

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C+D Clinical

Ulcerative colitis: an overview

The signs, symptoms and drug treatment of this uncommon condition

Key points

- UC is an uncommon chronic relapsing inflammatory disease involving the rectum and a variable extent of colon.
- Patients with UC present commonly with frequent bloody diarrhoea and low abdominal pain. Infection and Crohn's disease must be considered in the differential diagnosis.
- Initial treatment involves aminosalicylates and/or corticosteroids, administered by mouth or rectum depending on the extent and severity of disease.
- Patients with more severe disease or frequent relapses require immunomodulation with thiopurines and may be treated thereafter with infliximab to induce and maintain remission and mucosal healing.
- Acute severe relapses require admission and parenteral steroids. If this fails, then either ciclosporin or infliximab.
- Failure of medication or development of severe complications indicate surgery.

Dr Kirstin Taylor and Dr Adam Harris

Ulcerative colitis (UC) is a chronic inflammatory disorder limited to the colon and rectum, and characterised by relapses and remissions.

UC is not a common condition. A typical district general hospital serving a population of 300,000 would see 45 to 90 new cases per year, with 500 under follow-up.[1] However, it has a significant impact both on the individual and on society, as the condition presents at a young age and has the potential to cause lifelong ill health.

The aetiology of UC remains unknown. The consensus is that the disease is a response to environmental triggers in genetically susceptible individuals.[2] It is three times

The College of Pharmacy Practice

This course (module 1404), in association with multiple choice questions being published in C+D June 2, provides one hour's continuing education

Reflect

What is the main role of aminosalicylates in ulcerative colitis (UC)? Why should a patient on azathioprine be advised to report a sore throat? Do you know what the Montreal classification is?

Plan

If you feel you need to know more about UC, this article focuses on drug treatment while also considering the signs, symptoms and diagnosis.

CPD This article can help in the following CPD competencies: G1a, C3e. See www.tinyurl.com/194zu

Barium enema x-ray of the large intestine (coloured red) in ulcerative colitis

Science Photo Library

...s or non-smokers ... smokers, sex and social class ... associated and most patients present ... 15 to 30 years, although 10 per cent ... over the age of 60 years.

UC is a serious disease that previously carried a high mortality and morbidity. With modern management, the disease now carries a slightly increased mortality in the first two years following diagnosis, but from then on returns to the population baseline.[2,3] However, severe attacks are still potentially life-threatening and young patients can appear misleadingly well when in remission.

Signs and symptoms

The main symptoms of UC are bloody diarrhoea and low colicky abdominal pain. Diagnosis is based on clinical evaluation along with stool culture, blood tests for inflammation and anaemia, endoscopy of rectum and colon (to take samples) and radiological imaging.

These investigations are essential to confirm the diagnosis and to exclude the other common causes of similar symptoms such as infections (*Clostridium difficile* toxin, *E coli*, *salmonella*, *shigella*, *amoebiasis*), Crohn's disease, ischaemic colitis (in the elderly) or colorectal cancer.

Colonoscopy is used to assess disease extent: distal disease refers to proctitis (rectal involvement) or proctosigmoiditis; left sided disease is inflammation up to the splenic flexure, and disease that extends proximal to the splenic flexure is termed pancolitis. These three subgroups are felt to have clear biological relevance in terms of response to medical therapy, route of administration of treatment and the natural history of the disease, with respect to medication usage, hospitalisation or colectomy.[4]

Disease severity is classified according to clinical, endoscopic and radiological criteria, and blood test results. The Montreal classification[4] (Table 1) relies mainly on clinical criteria and so can be used easily in the community to determine those patients who may require escalation of treatment.

Treatment

The aim of treatment is to achieve and maintain clinical and endoscopic remission so that the patient can attain a high quality of life, reduce the risk of complications (massive bleeding or perforation) or colonic cancer, and to avoid colectomy.

Aminosalicylates – mesalazine (or 5-aminosalicylic acid/5-ASA), sulphasalazine, olsalazine, balsalazide
Available as tablets, enemas and suppositories, the aminosalicylates act on ... cells to mediate the release of ... cytokines and reactive ... Orally, they work through pH ... or controlled release or delivery by carrier molecules with release of 5-ASA after splitting by bacterial enzymes in the colon. Their main role is to maintain remission in UC.

Topical therapy is used for distal disease – suppositories for proctitis, and enemas (which can reach as far as the splenic flexure) for left sided or distal disease. Given orally, the choice of 5-ASA derivative is influenced by tolerability, dosing and cost. Maintenance therapy with 5-ASA drugs may reduce risk of colorectal cancer by up to 75 per cent.[5]

Side effects Side effects are largely related to intolerance of the sulphapyridine group of sulphasalazine, resulting in nausea, vomiting, dyspepsia, anorexia and headache (10 to 45 per cent).[5] Serious reactions are rare: Stevens-Johnson syndrome, pancreatitis, agranulocytosis or alveolitis. Eighty per cent of patients intolerant of sulphasalazine can tolerate mesalazine, olsalazine and balsalazide.

Rarely, interstitial nephritis or the nephrotic syndrome may develop. It is recommended that patients with underlying renal impairment, co-morbid disease or on other nephrotoxic drugs should have their renal function monitored while on 5-ASAs.[5]

Corticosteroids – prednisolone, budesonide, intravenous hydrocortisone
Corticosteroids are potent anti-inflammatory drugs, reserved for moderate to severe relapses of UC but have no role in maintaining remission. They are available orally, intravenously and topically. Strategies have been investigated to limit systemic effects while achieving good topical effects: budesonide is poorly absorbed with extensive first pass metabolism.

Doses Intravenous hydrocortisone at 400mg a day in divided doses is recommended for the treatment of severe UC. Higher doses offer no greater benefit and lower doses are less effective.[5]

Trials for the efficacy of oral steroids in mild to moderate disease are all more than 30 years old, but results show a significantly increased rate of disease remission compared with sulphasalazine. For prednisolone, a starting dose of 40mg a day is recommended. Greater doses show more frequent adverse events without yielding additional benefit. Too rapid a reduction in dose can be associated with early relapse.[5]

Side effects Side effects in the short term include acne, fluid retention, mood and sleep disturbance, dyspepsia, glaucoma and glucose intolerance. Longer-term side effects are more concerning: steroid-induced diabetes, metabolic bone disease (osteoporosis, osteopenia, osteonecrosis), cataracts, myopathy, accelerated atherogenesis and infection. Sudden withdrawal may cause acute adrenal insufficiency.[5] Early introduction of other immunosuppressants is vital to abolish the need for further steroid courses.

Thiopurines – azathioprine (AZA) and 6-mercaptopurine (6-MP)
The thiopurines act as immunomodulators by inducing T-cell apoptosis and are effective for active disease and maintenance of remission. They act as steroid-sparing agents and should be considered in:

- patients who have two or more steroid courses in a year
- those who relapse when prednisolone is reduced below 15mg
- those who relapse within six weeks of steroid cessation.[5]

Their onset of action is slow, taking three to six months for full effect. No direct comparison between the two drugs has been made in UC, but some patients intolerant of AZA are able to tolerate 6-MP.

Doses AZA – maintenance 2 to 2.5mg/kg/day. 6-MP – 1 to 1.5mg/kg/day.

Side effects The most frequently reported side effects are flu-like symptoms two to three weeks after treatment starts. Hepatotoxicity and pancreatitis are uncommon (2 per cent).[5,6]

A small proportion of people are genetically deficient in thiopurine methyl transferase (TPMT), the enzyme that metabolises thiopurines. Patients with leukaemia who are TPMT deficient are at increased risk of myelotoxicity but, in practice, only a quarter of cases of leucopenia related to thiopurine use are associated with low levels of TPMT.[6] Measurement of TPMT is

Table 1: Montreal classification of severity of UC

Severity		Definition
S0	Clinical remission	Asymptomatic
S1	Mild UC	Passage of four or fewer stools/day (with or without blood), absence of systemic illness, and normal inflammatory markers (ESR – erythrocyte sedimentation rate).
S2	Moderate UC	Passage of more than four stools/day but with minimal signs of systemic toxicity.
S3	Severe UC	Passage of at least six bloody stools/day, pulse rate of at least 90 beats/minute, temperature of at least 37.5°C, haemoglobin of less than 10.5g/100ml, and ESR of at least 30mm/h.

to therapy.[5] The ... recommend weekly full blood ... for eight weeks and then ... monthly. Leucopenia can develop suddenly between blood tests, although rare (less than 3 per cent). Patients must be advised to report a sore throat or other signs of infection quickly.[5]

Ciclosporin Available intravenously or orally, ciclosporin is a calcineurin inhibitor, preventing clonal expansion of T-cell subsets. It is considered in patients with severe disease, who have not responded to intravenous steroids. However, it has a high long-term failure rate and its main role is as a bridge to allow thiopurines to work.

Side effects It has a significant toxicity, in particular renal failure, opportunistic infection and seizures, especially in those with hypomagnesaemia and hypocholesterolaemia. Serum measurement is thus recommended.

Other, more common, side effects include gingival hyperplasia, hypertension, tremor, hirsuitism, hyperkalaemia, headache and abnormal liver function tests.[5,6]

Infliximab Infliximab is a chimeric IgG1 human-murine monoclonal antibody that binds with high affinity to tumour necrosis factor alpha (TNF-a), inhibiting its effects. It is licensed for use in moderate to severe active UC when there is an inadequate response to, or intolerance of, conventional treatment with steroids or thiopurines, and for steroid-refractory acute severe UC (to avoid surgery). Although the drug has received Nice approval for use in Crohn's disease, it is yet to receive Nice approval for UC (expected late 2007).

Single dose infliximab (5mg/kg) is effective as rescue therapy for steroid refractory acute severe UC. One Swedish-Danish study randomised 45 patients with steroid refractory acute severe UC to receive either infliximab or placebo.[7] Seven of 24 patients in the infliximab group underwent colectomy within three months compared with 14 of 21 in the placebo group, and the benefit was maintained at 12 months. The two ACT (Active Ulcerative Colitis Trial) outpatient studies used infliximab in patients with moderately active UC.[8] Their results are consistent, showing double the remission rate compared with placebo.

Dose Ideally patients should be treated with a thiopurine for the first six months of treatment with infliximab to reduce the risk of immunogenicity. Infliximab is given as an infusion of 5mg/kg, over two hours, at weeks zero, two and six. If the patient responds based on symptoms, blood results and mucosal healing, maintenance treatment is given at the same dosage, every eight weeks. Readministration after an interval of more than 16 weeks may result in a hypersensitivity reaction.

Contraindications Infliximab is contraindicated in patients with:

- tuberculosis (patients should have a chest x-ray before treatment to exclude this)
- other severe infections and abscesses
- intestinal obstruction
- multiple sclerosis or optic neuritis
- moderate or severe heart failure
- history of hypersensitivity reaction to infliximab or other murine proteins
- towards the end of pregnancy or in breastfeeding
- lymphoma.

Side effects Headache, upper respiratory tract infection, abdominal pain and nausea are reported in 20 to 30 per cent of patients. Serious infections, including tuberculosis, are seen in 4 per cent.[5]

The FDA (US Food and Drug Administration) has reported eight cases of the rare but aggressive hepatosplenic T-cell lymphoma in children who have received infliximab with AZA for inflammatory bowel disease.[9] There have been no similar reports in adults. It is unclear whether the underlying chronic inflammatory disease, use of AZA or infliximab or a combination of all factors was associated with this rare condition.

Useful websites:
British Society of Gastroenterology – www.bsg.org.uk
National Association for Colitis and Crohn's Disease – www.nacc.org.uk

References are available at:
www.dotpharmacy.com/bowelconditions

Dr Kirstin Taylor, BSc, MRCP, is a specialist registrar and Dr Adam Harris, MD, FRCP, is consultant gastro-enterologist, Kent and Sussex Hospital, Tunbridge Wells.

Continuing Professional Development CPD

Act

- Are there any terms or conditions with which you are not familiar mentioned in this article? Make sure you understand them completely.
- List three conditions with a strong genetic component. What is their incidence? Is there an ethnic factor? Are there any conditions that have a genetic component but are triggered by external factors (as perhaps is UC)?
- Many of the symptoms of UC are similar to other lower intestinal problems. List other conditions that may present in a similar way. Using this as a base, write down questions that may help you differentiate between them when dealing with patients.
- Check your PMRs to establish who might have UC. Are they prescribed corticosteroids long term? If so, find out why. What other medicines are they prescribed for UC? Ask them if they have had other drugs in the past. Did they change because of the side effects?
- Find out more about the effects of being genetically deficient in thiopurine methyl transferase. What is the danger of these patients taking a thiopurine? How would the patient recognise these adverse effects? How would you?

Evaluate

- Having read the article and worked through the Act section above, do you feel more confident in being able to discuss the treatment of UC with a newly diagnosed patient?
- There are a few conditions that present with bloody diarrhoea and low colicky abdominal pain. Could you ask the right questions to reach some sort of tentative diagnosis, which might indicate the patient has UC? (This does not suggest you can diagnose the condition!)
- Do you better understand the medication prescribed to treat UC?

10 MILLION REASONS TO STOCK

With a potential market of 10 million menopausal women, growing at the rate of 1,000 a day, this month's announcement that the three major pharmaceutical wholesalers have each decided to list **SYLK natural personal lubricant** is welcome news for the pharmacist.

Used predominantly by women going through the menopause, SYLK is also aimed at those being treated for breast or cervical cancer, for gynaecological conditions and others where hormone fluctuations and drug side effects may lead to atrophic vaginitis or vaginal dryness.

Developed and manufactured in New Zealand, where it is made from an extract of the kiwi fruit, SYLK is paraben, drug and hormone free.

As a pure and natural water soluble lubricant, SYLK is a perfect substitute for the body's natural lubricating system. And with a pH level the same as the vaginal environment, the product is also gentle and non-irritating, simulating natural secretion and ensuring love-making is more comfortable and enjoyable. Unlike most other supplements and lubricating gels, SYLK has no chemical base, making it fully natural in every respect and totally safe to use with tampons and condoms.

Minimal footprint

Packed in display outers of six, SYLK takes up minimal space on shelf or on the counter, while providing pharmacies with a healthy £17 return per outer. Attractive information leaflets and sachet samples are also available, with more than 500,000 leaflets a year having already been distributed through doctors' waiting rooms.

"Some three million bottles have been sold worldwide," says Tony Shelley, managing director, SYLK Limited, the UK distributors. "And we have stacks of letters testifying to its effectiveness, both from consumers and healthcare professionals alike."

The introduction of SYLK into the pharmacy sector will be supported by an extensive public relations and sampling programme. This will target health and medical correspondents of national and regional daily newspapers, health writers and problem page editors of women's magazines, publications aimed at practice nurses and specialist organisations supporting women's health.

WHY USE SYLK?

Every woman at some stage in her life experiences vaginal dryness. Hormone fluctuations as women approach the menopause or a hysterectomy are among the most common causes. Other reasons include chemical changes within the body brought about by childbirth, breast feeding, the use of tampons and other vaginal inserts, medications, oral contraceptives and poor or infrequent sexual activity. Such discomfort can affect a woman's self confidence, especially during sexual intimacy.

SYLK is extremely beneficial and soothing to people who experience an inadequate supply of natural lubrication. Many women can develop irritations with chemically or hormonally based vaginal lubricants. Since SYLK contains nothing artificial, being derived from a natural plant source, it is non-irritating and safe.

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DAK248

A Practical Approach...

It is lunchtime at the Update Pharmacy and pharmacist David Spencer has popped out for a quick lunch with an old friend. Pre-registration pharmacy trainee, Julia O'Reilly, is alone in the dispensary preparing repeat prescriptions for collection later in the afternoon when she is called to the counter to take in a prescription. She does not recognise the young person handing it in and is puzzled by the prescription.

"Do you usually bring prescriptions in here?" she asks

"I don't know," the girl replies, "I've just started working there and they told me to take this prescription down to the chemists, and I thought this must be this one."

"Can you hold on a minute please, I just need to check this out," says Julia, taking the prescription into the dispensary where she reads through it again. It is on a standard FP10 (English) form, but "Happy Days Residential Home for the Elderly" appears in the space for the patient's name. The prescription itself reads:

"Paracetamol 500mg tablets x 300
Senna 7.5mg tablets x 300
Sodium alginate 500mg, potassium carbonate 100mg/5ml suspension, 10x500ml
Corn rings, 10 packs
I have 34 of the residents in this home in my care."

It is duly signed and dated.

Julia looks in the Drug Tariff but cannot find anything to help her. She goes out to the young girl again. "I'm sorry," she says, "but I don't know whether we can dispense this. I'd have to ask the pharmacist and he's out at lunch. Anyway, I couldn't give the medicines out to you until he gets back."

"That's OK," replies the girl. "They just said to leave it and our van driver will come to pick up the stuff tomorrow."

Questions

1. Can this prescription be dispensed?
2. Is any information given in the Drug Tariff?
3. If the prescription can be dispensed, what fee is payable? Answers →

CPD

This article can help in the following CPD competencies: C3b, C5a, C6a. See www.tinyurl.com/194zu

Simvastatin switch could save billions

Switching patients from branded statins to generic simvastatin could save billions of pounds, according to the Drug and Therapeutics Bulletin.

A review weighing up the pros and cons of the five prescribable statins in the UK found that switching one patient with existing CVD, or one person with a CVD risk above 20 per cent, from atorvastatin 10mg daily to simvastatin 40mg daily would save £1,000 over five years.

If the million people in the UK currently on atorvastatin 10mg or 20mg daily were moved to simvastatin 40mg daily, plus simvastatin 40mg daily for the 1.6 million additional prescriptions of statins needed to meet Nice guidelines on primary prevention, the NHS could save as much as £2 billion over the next five years.

Evidence from a general practice that had switched patients from atorvastatin to simvastatin showed that taking into account pharmacist and GP time, letters, appointments and cholesterol tests, the net savings were around £12,700 for the first year, and expected to rise to £14,700 per year in future years.

However, the DTB warned that switching is not appropriate for all patients, and should be considered carefully with individuals.

Atorvastatin should be reserved for second-line treatment and patients intolerant to simvastatin, and there is no reason for use of fluvastatin or rosuvastatin routinely, the DTB concluded.

For more information:
Drug and Therapeutics Bulletin, May 2007

Diabetes prevention drugs unjustified

Clinical use of glitazones to prevent onset of diabetes cannot currently be justified, say US experts.

After analysing data from several trials, including the recent DREAM study, they found the evidence was not yet strong enough to justify medicalising a large proportion of the population.

Lead researcher Professor Victor Montori, of the Mayo Clinic College of Medicine, said the results of the DREAM trial, which was halted early because of apparent benefit of rosiglitazone, had prompted aggressive promotion of the drug as a preventive therapy.

However, the authors of the new study calculated that even under the most optimistic assumptions, patients offered rosiglitazone for prevention would end up taking more pills.

They argued that lifestyle changes should instead be advocated, as modest weight loss and physical activity are equally effective, much safer and cheaper.

Clinicians who offer patients glitazones to prevent diabetes are offering "certain inconvenience, cost, and risk for largely speculative benefit", they warned.

Professor Montori added: "Clinical use of glitazones to prevent diabetes is, at present, impossible to justify because of unproved benefit on patient important outcomes or lasting effect on serum glucose, increased burden of disease labelling, serious adverse effects, increased economic burden, and availability of effective, less costly lifestyle measures."

For more information:
BMJ 2007; 334: 882-84

A Practical Approach... this week's answers

1. This is a 'bulk' prescription and three of the four items can be dispensed. A 'bulk' prescription is an order for two or more patients, bearing the name of a school or institution housing at least 20 people, and the prescribing doctor must be responsible for the treatment of at least two of them. Only medicines and appliances that are not POM can be ordered. Paracetamol 500mg tablets in quantities greater than 32 are POM, so cannot be supplied on this prescription.
2. Yes, but it is not easy to find. It appears as Note 9 in Part VIII, Basic Prices of Drugs, but there appears to be no reference to this in the list of contents or index.
3. The standard fee of 90p per item is payable. A separate and substantial fee for 'bulk' prescriptions used to be paid, but it was discontinued when the new contract started in 2005.

Nice ICS combination draft

A Nice consultation document on the use of ICS in adults and children over 12 years advises that decisions on combination or separate devices should be made on an individual basis, and where both are equally appropriate cost should be the deciding factor.

Existing advice says combination devices should be considered for asthma sufferers who need an inhaled corticosteroid and a long-acting beta-2 agonist.

The cheapest ICS and high-dose ICS products should be chosen, the draft guidance states. A press-and-breathe pressurised metered-dose inhaler (pMDI) and suitable spacer is recommended in the first instance, but alternatives can be considered if the patient is unable to use pMDI and spacer effectively, or if it is not appropriate for the chosen agent.

The consultation document, which is open for comments until May 15, should be considered in conjunction with BTS/SIGN 2005 guidelines, which offer a stepwise approach to asthma management, dependent on control of symptoms.

Under the gold-standard guidelines, patients with mild intermittent asthma should be treated with an inhaled short-acting beta-2 agonist as required.

Step two is adding in a regular ICS, step three adding on a long-acting beta-2 agonist, step four, increasing ICS dose or adding in a fourth drug such as a leukotriene receptor agonist and step five is regular or frequent oral steroids.

Diabetes virus association found in rats

Researchers are speculating about a possible link between the Ljungan virus and diabetes, following the discovery that a widely researched laboratory 'diabetes rat' strain of inbred rats is infected with the virus.

The rats have been closely studied because large numbers of them develop diabetes after two months of life. The cause has previously been assumed to be genetic, but now the possibility that the diabetes may be caused by virus infection is being considered.

The researchers working with the Swedish research company Apodemus AB and at the University of California have previously shown that laboratory mice develop diabetes if infected with the Ljungan virus.

Although the discoveries do not prove that the virus causes diabetes in the laboratory rat, researchers at Apodemus and the Karolinska Institute in Stokholm are experimenting with antiviral treatments.

The virus has been shown to be present in wild lemmings and voles with diabetes, and to cause still-births in humans. There is further evidence suggesting the prevalence of diabetes in a given area covaries with numbers of rodents.

New depression advice from Nice

Nice has updated its guidelines on depression and anxiety to take account of MHRA safety advice on venlafaxine.

Under the new recommendations, venlafaxine can be considered as second-line treatment for moderate to severe depression but physicians should take into account the higher cost and increased likelihood of patients stopping because of side effects.

Patients with uncontrolled hypertension should not take venlafaxine, and blood pressure monitoring is recommended.

Venlafaxine should only be prescribed at high dose (300mg/day or more) under the supervision or advice of a specialist mental health medical practitioner. Physicians are also warned of potential drug interactions.

For more information:
www.nice.org.uk

Coeliacs wait years for diagnosis

People with coeliac disease do not receive their diagnosis until on average 13.1 years after symptoms appear, according to research sponsored by Coeliac UK.

Many patients make repeated visits to their GP before learning the cause of their illness, the University of Oxford research team revealed.

The best recognised symptoms are bloating, diarrhoea, anaemia, chronic fatigue and weight loss. However, patients may suffer vomiting, constipation, breathlessness, depression, weight gain and mouth ulcers, neurological problems, migraines and autoimmune disease.

Children may exhibit behavioural, learning or concentration problems, irritability, listlessness and failure to thrive.

One person in 100 is believed to be at risk of the condition, said Coeliac UK, but only one in eight has been diagnosed.

In brief

Using antidepressants in addition to a mood stabiliser does not improve depressive symptoms in bipolar disorder, a US study has suggested. However, most European experts consider antidepressives to be useful and unlikely to induce mania in bipolar disorder.
New Eng J Med 2007; 356: 1711-22, 1771-73

Roche has announced plans to reduce production of Tamiflu because supply has surpassed demand. Roche said it would maintain a buffer and would be able to respond speedily to a surge in demand.

The scientific committee of the European Medicines Agency has granted a positive opinion recommending approval of Abbot's Crohn's disease treatment adalimumab (Humira). It has also announced opinions in favour of the primary insomnia treatment melatonin (Circadin) developed by Neurim Pharmaceuticals EEC, and the Janssen-Cilag antipsychotic paliperidone (Invega).

The over 65s feel 'unfairly targeted' by flu vaccination policies, a Welsh study suggests. Some felt they were singled out for vaccination despite being healthy and others thought having the jab would make them ill. Health education campaigns need to challenge the perception that influenza poses no risk to healthy older people.
Br J Gen Pract 2007; 57: 352-58

Taking low dose aspirin does not protect older women against cognitive decline, despite evidence to suggest that anti-inflammatory drugs may be protective, a large US study has reported.
BMJ, published online April 27, 2007

The Novartis hepatitis B virus treatment telbivudine (Sebivo) has been approved by the European Commission. The treatment does not cure the infection but suppresses the virus and reduces the viral load, which in turn lowers the risk of serious complications including cirrhosis and cancer.

AAH

AAH Pharmaceuticals has launched an electronic proof of delivery system (ePOD), making it the first full line wholesaler to move towards throwing out traditional paper-based systems in favour of a fully traceable, customer-focused approach.

e-REVOLUTION

FOR PHARMACY DELIVERIES

The move follows a massive £1.2m investment programme to design a bespoke system able to cope with the complexities of pharmaceutical wholesaling.

It will minimise all possible human error concerning the dispatch and delivery of an order and ensure that customers can track their orders 'live' – which AAH says is a vital enhancement to the twice daily service of time-critical medicines.

Steve Dunn, group managing director at AAH, says, "We asked our customers what they see as the drivers for excellent customer service. "They told us that it is all about deliveries: the timing, the accuracy, the communication with, and the knowledge of, the driver and the ability to resolve issues in a timely fashion. With ePOD, we can meet all of those needs and ensure that AAH is continuing to respond to the challenges thrown up by the rapidly evolving market place."

How does it work?

ePOD comprises a handheld, electronic terminal that links live to AAH computer systems via GPRS (satellite). Drivers will use the device to scan in all their deliveries for the day, using a bar code reader. They will also upload their route using its satellite navigation system.

When the driver arrives at the pharmacy the handheld device will prompt the driver on how many and which boxes are to be delivered. The customer will be asked to confirm receipt of the delivery by signing directly onto the screen of the terminal, keeping the record electronically. Customers will sign for the whole consignment and, as per Home Office guidelines, controlled lines will be signed for separately.

The system has been designed to be flexible and will allow drivers to scan in returns, as well as add a one off delivery, if the customer needs it. Once the delivery is complete AAH's main computer system will be updated automatically and the information will be visible within 15 minutes.

"This is just the first phase of the scheme – we are already looking at developing the package and introducing more customer service enhancements. ePOD will also help us move towards a system in which all products and medicines are fully traceable – from the moment we purchase them to when we deliver them to our customers," concludes Dunn.

The benefits

Although customers will not see any change to how they receive their goods at the time of delivery, ePOD will offer significant benefits to them.

The ePOD pilot will be launched in Bristol during May and will then be rolled out to the remaining AAH distribution branches during the summer.

• Drivers will be able to contact and alert the customer or the AAH customer service team if there are any hold-ups that will affect the sometimes time-critical, twice daily deliveries.

• Deliveries will be accurate and there will be a traceable record of what was delivered, when and by whom, ensuring that issues and queries can be resolved easily.

• Live updates will be sent to AAH's main computer system as each delivery is made. This will allow the dedicated customer service team to respond immediately to customers' queries and concerns.

Piriton reacts to hayfever season

A £4 million marketing campaign for Piriton Allergy Tablets begins this week. The pharmacy-only treatment will be seen on TV, outdoor and press advertising, reports GSK.

Running until the end of August, the TV activity comprises three 20-second ads, each highlighting bizarre allergies in humorous scenes – sheep and a photocopier – and the more obvious hayfever scenario. The strapline is 'Millions of allergies. Only one Piriton'.

A short GMTV sponsorship package is running prior to National Allergy Week (May 21-25).

National newspapers and lifestyle magazines will maintain the 'millions of allergies' theme with ads running from mid May until early August. Parenting magazines will be used throughout the year to highlight Piriton Syrup's suitability for children aged one and over.

Outdoor activity will run during June and July within the M25. Commuters on the London Underground will be targeted as the season peaks, adds GSK.

Product info:
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

New image for Simple

Skincare brand Simple has been updated with new-look packaging and new products. The range now features more than 100 products.

Kind to Eyes balm contains jojoba oil, shea butter and pro-vitamin B_5 to moisturise and refresh the skin around the eyes. Suitable for daily use, the balm can be applied to give eyes a lift after a late night, says the company.

For consumers wanting to boost their complexion, Simple Daily Radiance is a new range containing mango extract and skin-illuminating ingredients. Targeting the 25+ age group, the range includes a foaming cream cleanser, moisturiser with SPF10 and an eye cream.

Simple Deep Clean hand wash contains provitamin B_5 and chamomile to help maintain moisture levels and prevent dryness. Red tea adds antioxidant activity and aroma is provided by citrus oils.

For users aged 40+, Regeneration Plus Moisture rich anti-wrinkle cream is a new offering for mature, dry skin. Containing iris flower extract, the product is said to help reduce wrinkles and firm the skin.

The Simple suncare range, exclusive to Boots, now boasts an SPF30 spray for children.

Prices: from £3.75 for Kind to Eyes balm to £12.99 for Regeneration Plus cream

Product info:
Accantia Health & Beauty
Tel: 0121 327 4750

Lavender treats from Yardley

Lavender Spa is a new range of toiletries from Yardley.

Designed to appeal to a younger audience, the products have a contemporary look. There are four products in the range – eau de toilette, body spray, shower crème and body lotion – all containing aloe vera alongside the lavender.

Further aromas are provided by mandarin, bergamot, pear, orange blossom, rose, lily and jasmine on a base of amber, sandalwood, musk, tonka bean and precious woods.

As well as being gift purchases, Yardley sees the products as daily treats for self-purchase.

Price: from £2.95 (100ml body spray) to £9.95 (50ml edt)

Product info:
[illegible]namead
[illegible] 01276 6[illegible]4000

Products advertised on TV next week

Buscopan: GMTV
Deep Heat: All areas except GMTV, five
DulcoEase: C4,GMTV,Sat
Frontline: GMTV, Sat, five
Full Marks: GMTV, C4, five, Sat
Haliborange Omega-3: GMTV, Sat
HemoClin: GMTV, Sat
Kwai: C4
Lyclear Spray Away & Repellent: GMTV, Sat
Nivea Light Feeling Lotion: All areas except GMTV
Seabond: All areas
Zantac: All areas
PharmaSite for next week: Bazuka – windows, Bazuka – in-store, Allergan Refresh - dispensary
Pharmacy channel: elave, Complan, Piriton

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Fungal nail infection? Punish the Criminails with a once-weekly!

OTC BRAND OF THE YEAR* BACK ON TV AGAIN FROM MAY 2007!

Essential Product Information: Presentation: Curanail 5% Nail Lacquer contains 5% w/v amorolfine. **Indications:** Mild distal and lateral subungual Onychomycoses caused by dermatophytes, yeests end moulds limited to up to 2 nails. **Dosage and Administration:** Adults Only – Apply to the affected finger or toe nails once weekly (see summery of product characteristics for full technique). Treetment duration depends on intensity end localisetion of infection. Generelly, six months (finger nails) and nine to twelve months (toe nails). Not recommended for use in petients under the age of 18. **Contra-Indications:** Hypersensitivity. No experience in pregnancy and lactation, it should therefore be avoided. **Precautions and Warnings:** Avoid contect with eyes, eers end mucous membranes. Patients with predisposing conditions such es peripheral circulatory disorders, diabetes mellitus and immunosupression should be referred to e doctor. Patients with nail dystrophy and destroyed nail plate should also be referred to a doctor. **Side Effects:** Adverse drug reactions are rare. Nail disorders (e.g. neil discoloretion, broken nails, brittle nails) mey occur. These reactions can also be linked to the onychomycosis itself.

System Organ Class	Frequency	Adverse drug reaction
Skin and subcutaneous tissue disorders	Rare (≥1/10000, ≤1/1000)	Nail disorder, nail discoloration, onychoclasis
	Very rare (≤1/10000)	Skin burning sensation, contact dermatitis

Interactions: No specific studies involving concomitant treatment with other topical medicines. Avoid nail varnish or artificial nails. **Packaging Quantity and Cost:** Peck containing 3ml nail lacquer, cleansing swabs, applicators end nail files. 3ml (R) **£18.61. MA number:** PL 10590/0049. **Legal Category:** P. **Full prescribing information is available from:** Galderma (UK) Limited, Meridien House, 69-71 Clarendon Road, Watford, Hertfordshire, WD17 1DS. United Kingdom. Tel: +44 (0) 1923 208 950 Fax: +44 (0) 1923 208 999. **Date of Revision:** February 2007.

References: 1. Reinel D *et al. Dermatol* 1992 ; **184** (Suppl 1) : 21-24.

AMO/66/0307 March 2007

Pharmacy training materials are available at

www.curanail.co.uk

*2007 OTC Marketing Awards

ALLERcalm aids allergic reactions

First aid for relief from allergies is available in the form of ALLERcalm tablets from Actavis.

The P tablets, which contain chlorphenamine maleate 4mg, are said to calm allergic reactions to food, medicines, pets, insects, hayfever and other irritants.

According to Richard Hollies, OTC director at Actavis, one in three Britons is affected by allergies at some point in their lives, possibly caused by an increase in dust mites and processed foods containing chemical preservatives.

The dosage is up to four tablets each day, which means it can be adjusted according to the severity of the reaction.

Price: £1.75 for 28
Pip code: 324-4712
Actavis
Tel: 01271 311200
www.actavis.co.uk

Believe in the power of Ibuleve

Ibuleve, the painkilling gel, is appearing on national TV channels this month in a part dance, part music video featuring the Robson and Jerome hit, 'I Believe'.

The ad uses the song's lyrics to evoke the freedom of movement that Ibuleve pain relief gel can bring to those suffering from backache, rheumatism and common arthritic conditions.

Product info:
Dendron
Tel: 01923 229251

Products in brief

Flex those joints

A Joint-Flex 1000 range has been launched by Health Perception.

There are two daily variants: Joint-Flex 1000 provides 1,000mg glucosamine while Joint-Flex 1000 Rosehip offers glucosamine, chondroitin and rosehip extract.

Prices: £9.99/60, 327-8165; rosehip £11.99/60, 327-8181

Health Perception
Tel: 01252 861454

Glucosamine in meltdown

Glucosamine Meltdown 1,500mg is a new orodispersable melt-in-the-mouth orange-flavoured once daily version of this food supplement that is widely used in the managed care of osteoarthritis.

It avoids the difficulty in swallowing that is frequently encountered with large conventional 1,500mg glucosamine tablets. It contains glucosamine HCl, not the more commonly available glucosamine sulphate 2KCl.

Price and Pip code: £14.98/30, 327-3554
IXL Pharma
Tel: 01604 889855
www.cozachewmeltdown.com

Time for wholesale

Wholesalers are efficient and have built unique strengths with the twice-daily delivery model and intimacy with customers at the NHS coal face. So why is this being abandoned in favour of direct to pharmacy models? Can wholesaling survive in its existing guise or in any other? **Jeremy Poole,** an independent consultant with extensive experience in wholesaling, takes stock of the situation

Every day a new announcement seems to be made regarding distribution plans of the big pharmaceutical companies. But where has this come from and why now?

What has happened to UK wholesaling, you might ask? At the macro level the UK has not escaped two established international trends:
1. Concentration of wholesalers and their customers – the limited channel distribution (LCD) model is a plausible end game to this process.
2. Vertical integration, downstream into customer acquisition and upstream into the provision of outsourced services to the pharmaceutical industry, which has continued apace.

Before looking at the UK specifically, it's worth reminding ourselves that the wholesaler's traditional core skill is the consolidation and aggregation of goods from a number of suppliers into orders for its customers so as to minimise transaction costs. Depending on relationships, the wholesaler may be acting variously as distributor, agent or trader. Around this are often built additional services to both customers and suppliers, sometimes becoming separate businesses. This varied and pivotal role in the supply chain brings influence, creates identity issues and makes them particularly subject to the basic forces driving industry competition (see Anatomy of 'Wholesale' diagram). For UK pharmaceutical wholesalers, the major profit driver remains the volume of individual prescription items that they can supply at the highest unit profit. To maximise this, they have become symbiotic with pharmacy and now supply a raft of mission-critical services, few of which are self-funding.

Arguably it is this business model that has led to the current tensions with big pharma. The latter believe, with some justification, that through the discount, over which it has little control, it subsidises both the distribution of all products (including competitive) and the provision of services, from which it sees no obvious benefit.

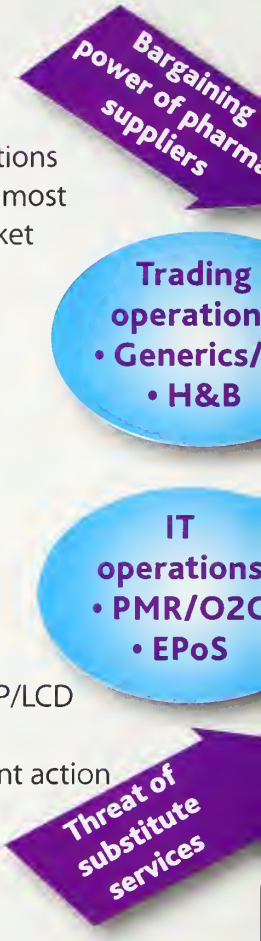
Worse, it is in the interest of the wholesaler (and its customers) to substitute a higher margin product such as a PI or generic wherever possible. There are then some grounds for the current dissatisfaction, and wholesalers' trading activity lies increasingly uncomfortably with its LSP (logistics service provider) functions.

Leveraging provision of other goods and services, including 'non-medical' adds complexity and also suggests the opportunities and threats which will determine the future of wholesaling.

Over the last decade the NHS Plan has had a profound effect on the medicines supply chain and helps bring some clarity to the options facing its players. It is convenient to think of the chain as three streams of activity: movement of product, movement of cash and data and the provision of added value.

Once these activities were centred at the point of dispensing, invariably a retail pharmacy, but this has changed.

Anatomy of 'Wholesale'



Movement of product

The wholesaler's stock in trade is the ability to aggregate and consolidate many products into a single delivery. The traditional UK pharmacy twice-daily model has few, if any, peers in terms of efficiency and customer service. It optimises minimum stocking of expensive drugs while reacting quickly to patient need – in short, the drug is near the patient, a key focus of the NHS Plan. An alternative is direct to pharmacy (DTP) and the challenge to wholesalers here is to counter a tracked consignment which can be delivered by noon next day for less than £5. The appeal to manufacturers is that they pay an activity based fee, directly linked to the service they receive with no cross-subsidisation of other services.

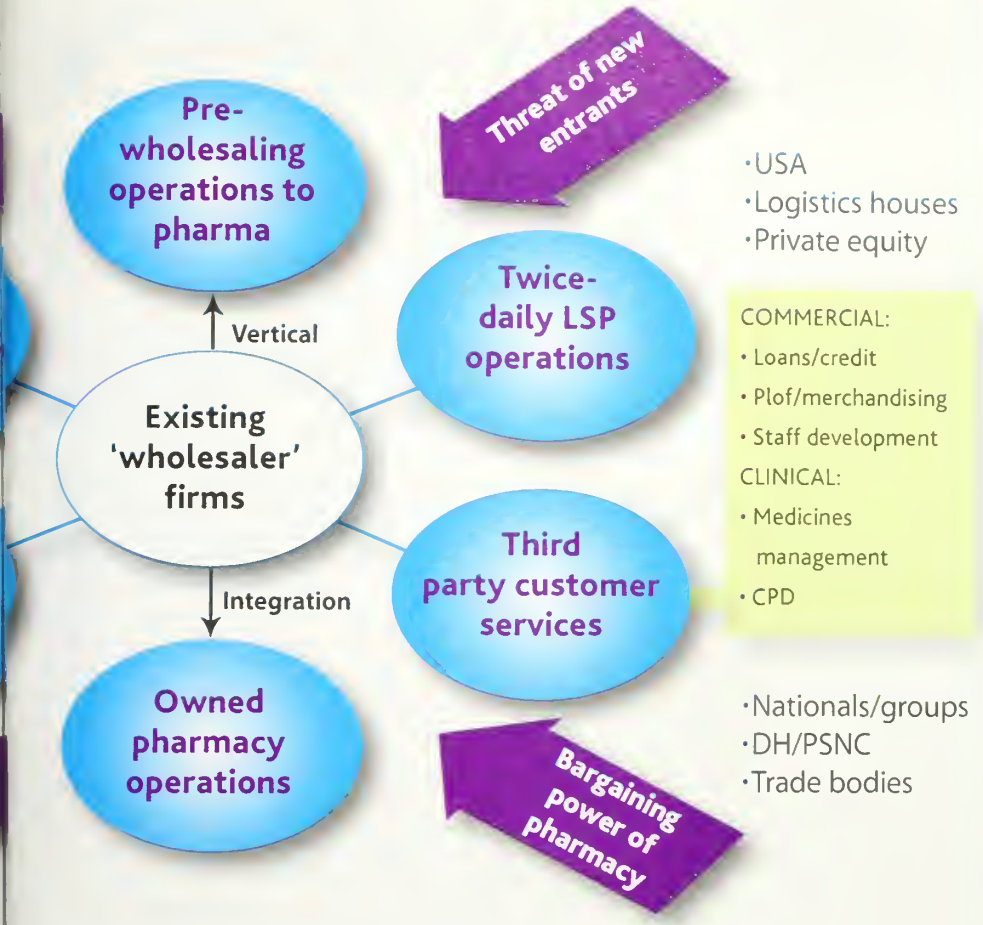
Administrative inefficiency apart, it works for minimum value orders and relatively expensive drugs that are not needed urgently. Some wholesalers operate a DTP through affiliated pre-wholesalers or parcel specialists but recognise it can never replace the patient proximity of regional warehouses – hence the hybrid PfAB (Pfizer–Alliance Boots) model. Urgently required drugs are of little use in a site 200 miles away, closed for the weekend.

Movement of cash and data

Apart from consolidating goods, a key benefit of pharmacy wholesaling is the aggregation of transactions, enabling most customers to pay for hundreds of items against a monthly statement and generally to streamline administration. This transactional information is invaluable to all in the supply chain and yet progress to transparency is slow. This is partly due to wholesalers struggling to reconcile their trading profile against their LSP functions. It is also compounded by the myriad of systems and vested interests that impact the arcane way in which the UK pays for its drugs and related services. Take the 12.5 per cent custom and practice discount on branded products, largely passed on by wholesalers to their customers. This is in turn clawed back on an estimated basis by the DH, partly to reappear as retained purchase margin. The money is a distribution margin allowed off NHS prices, against supplies distributed through wholesalers (PPRS 99) with the objective ... to encourage efficient and competitive supply of medicines to the NHS (PPRS 05). Companies feel it is for them to direct the use of this money, providing discounts and services to best suit their own needs. It might be argued that it is NHS money and bringing wider benefits to the medicines supply chain such as subsidised PMR systems is no bad thing. In addition, the DH would doubtless welcome more transparency in tracking taxpayers' money.

The NPA and the British Association of Pharmaceutical Wholesalers have called for a full

(After Porter – Competitive Strategy – The Free Press 1980)



change?

supply chain review. With the OFT medicines distribution and PPRS reviews in place there will be no better opportunity for wholesalers to cement their central role than by lobbying all stakeholders, including government, with radical alternatives.

Provision of added value

Here we see the biggest impact of the NHS Plan on the wholesaler/pharmacist symbiotic relationship. Delivery to patients' homes, medicines management protocols and the enablement of pharmacy to provide an increasing range of primary care services are vivid examples. The national emphasis today lies in patient pathways and packages of care.

Despite employing NHS liaison managers, some actions of the major pharmaceutical companies seem out of step. Costs and therapeutic outcomes can no longer revolve around individual drugs in the way that the 'magic bullets' revolutionised healthcare for the previous generations and established the business model. Separately and collectively they account for a considerable proportion of prescription value, but the same is hardly true of prescription volume and completed patient episodes. Is it so unreasonable that through an efficient intermediary, high cost drugs might subsidise wider dispensing and better patient care. The OFT concept of patient focused, value based pricing must surely recognise factors beyond pure pharmacological effect?

While wholesalers need to be more open, they already provide a ready conduit, through which services can be channelled, mitigating fears of pharma companies being too closely involved in packages of care.

As the diagram above shows, the major national, or rather international, wholesalers have already morphed into end to end supply chain companies able to absorb one or two LSP agency losses. They can compete in all areas; theoretically they are capable of repackaging product, dispensing it and delivering it seamlessly from consolidated sites.

For regional full-liners, without a legal ruling in their favour, limited channel distribution is a bigger hit, perhaps heralding a final round of consolidation. The alternative to acquisition (perhaps by logistics or global entrants) is to focus on trading, downstream patient-driven services or upstream services to manufacturers. The perceptive millennium acquisition of Ashfield by UDG provides an object lesson. In either case a more open, sharing approach in the supply chain is essential, together with 'wholesalers' being clear on what business they or their components are actually in. A searching national review is highly desirable in which wholesalers have little new to fear and everything to gain.

jfpoole@msn.com

Whose move is it?

Counterfeiting is the last straw

The current situation of pharmaceutical companies looking to supply pharmacies directly shouldn't be a surprise. A decade ago GSK adroitly seized first mover advantage with the 'agency scheme'. Despite an initial partisan furore, the supply chain has largely settled into a mature partnership with some all round benefit. GSK gained much enhanced transactional control and information, which translated into better product availability, direct margin control and a tool against entrepreneurial substitution of its products. These remain high on big pharma's wish list, yet despite consultancy reviews, rumours of consortia and tempting offers from logistics houses, seemingly little has happened until Pfizer led with its chin. Why did it take so long and what has changed?

There were barriers to following GSK's stratagem, particularly the production of company specific invoices for multiple parties in short cycle times. However, before considering how the supply chain has evolved and if wholesalers prepared for the current move, we should consider the circumstances of March 5. There are some critical differences in the Pfizer–Alliance Boots **(PfAB)** model against the GSK model.

Firstly, the straw that broke the camel's back was apparently counterfeiting. This is unlikely to be a key driver since it has only been found to be a minor problem in the UK market. The UK is a highly regulated supply chain, run by professionals. Counterfeiting must surely be contained and an early recommendation to wholesalers is to ensure that the organisational balance of power between traders and gatekeepers is appropriate.

Secondly, the arrangement is single channel **(SCD)** rather than multi channel distribution **(MCD)**, an effective monopoly that cannot be in anyone's long-term interest. Solus blue chip distribution deals are initially attractive to investors but the enhanced income stream is prone to reduce or even disappear at the next round. Alliance Boots' ability to deliver an impartial and adequate service is currently being tested, but there is little doubt that with an additional national partner or two, normal services could be maintained by a limited channel model **(LCD)**. Commercial or legal factors made it inevitable that others would enter the fray with eventual joint distribution of Pfizer or by bidding for logistics service provider **(LSP)** services to other companies waiting in the wings. OFT permitting, this model will now be tested by AZ's intention to include AAH. Some choice is therefore likely in the longer term but this is cold comfort for smaller regional BAPW members and their customers.

The final difference relates to the need for a separate 'Pfizer-only account' and its increased administrative burden on pharmacy. A multi company consortium approach to the order to cash **(O2C)** cycle would nullify some of these perceived problems, reduce costs and overcome the need for separate paperwork a la GSK. It would be surprising if it is not already under review.

There aren't many companies in the UK which process more transactions than a High Street bank. But it's part of daily life for the country's leading wholesaler AAH Pharmaceuticals

Wholesaler

The statistics are staggering:

- AAH delivers over one third of drugs dispensed in community pharmacy and 25 per cent of drugs used in secondary care
- Every day its drivers deliver around 2.6 million items
- AAH's Bristol depot alone fills 8,000 boxes a day – that's one every 10 seconds
- The company carries a comprehensive range of some 25,000 product lines
- AAH processes an invoice every 3 seconds
- The Merchandising team merchandise over 50,000 metres of retail shelving every year
- Vantage Health Watch business managers have supported the implementation of over 2,500 diagnostic & medicines management services.

Vince Hannawin at AAH's Weedon Depot with van driver Mick Beasley and th record number of BNFs they collected for Pharmai

Behind these numbers are 4,500 dedicated staff who ensure customers receive their deliveries on time and provide a range of healthcare, IT and finance services to pharmacists, hospitals, doctors, Ministry of Defence bases and prisons.

In an increasingly competitive industry, AAH group managing director Steve Dunn believes that supporting pharmacists, at a time when the pharmacy landscape is rapidly changing, is AAH's most important role. "Our job is to understand what is going to happen in the pharmacy world tomorrow, today.

"We believe that pharmacy is best placed to deliver even more primary healthcare services, thereby helping to meet the Government's objectives to cut waiting times, provide healthcare in the community and in the home. This means that AAH has to provide the best support and the best services to our customers to make sure that they are in a position to take full advantage of this opportunity."

To help the branches continue to provide first class customer service, AAH has invested extensively in supply chain operations, from distribution centres and IT to the AAH fleet.

This year, AAH has become the first full line wholesaler to introduce a bespoke electronic Proof of Delivery (ePOD) system (see page 31) which will streamline delivery systems, allow even better customer service and, eventually, a fully traceable drug lifecycle.

A new, groundbreaking warehouse distribution centre in Stoke-on-Trent has been designed to the highest environmental specification, helping AAH meet its green business targets.

Dunn says, "The whole ethos of AAH is based around building mutually beneficial partnerships with our customers and our suppliers. It's in our vision and it's in our mission statement. This year will be no different and we will be exploring new business models all aiming to give the best possible support to pharmacy."

Group managing director Steve Dunn

Supporting independent pharmacy purchases and refits

Statim Finance, an AAH company, offers a comprehensive support and advisory service to new and existing independent pharmacy customers of AAH. It has helped more than 3,000 pharmacists buy or refit a pharmacy since 1985.

Statim Finance's loan guarantee scheme, in which the major UK banks are lending partners, has enabled many pharmacists to acquire their own businesses at a time when traditional bank lending has been too expensive or unavailable.

The success of Statim is based on the success of the pharmacists we support. We know that one size does not fit all and so offer flexible and bespoke schemes to meet the needs of each individual applicant

Statim's head of finance, Kevin Nichols

"As a result, Statim is the market leader and we now represent 50 per cent of independents who have used us either to buy a new pharmacy, or to refit their existing one", says Kevin Nichols, Statim's head of finance.

Vantage merchandising team

navigates

THE NEW WORLD OF PHARMACY

All the managers in the Statim team have a background in finance and dealing with small and medium-sized businesses, making them ideally suited to helping pharmacists make the most of their business.

Meeting the IT challenge

AAH has been at the forefront of testing and delivering IT systems that will meet the demands of moving to a paperless, electronic prescription service (EPS) in England, Scotland, Northern Ireland and Wales.

LINKEvolution, AAH's bespoke IT system, was the first in the UK to gain Release 1 EPS accreditation from NHS Connecting for Health (CfH) and meant customers were able become EPS compliant well in advance of competitors.

By the end of 2006, 70 per cent of AAH pharmacists were on board, backed by a well-staffed helpdesk and full field support.

"We believe that IT is not the start and end point, but an enabler to allow pharmacists to achieve their business goals," explains Leon Rudd, customer technology controller.

"We moved early because our view has always been that people who adopt EPS quickly are at a huge advantage. Early familiarity boosts staff confidence and ensures the pharmacy is prepared for the move to the totally paperless system that will follow EPS Release 2."

AAH believes the experience gained from R1 development and deployment, coupled with the ongoing architectural development of LINKEvolution, means it has been able to focus on the requirements for R2 and will be ready to meet the timeframe set by CfH.

Flexible support from Vantage

Vantage offers added value with a suite of pay-as-you-go professional and retail services. These are flexible, allowing a pharmacist to choose whichever Vantage service or mix of services that works best for them.

"We continually monitor new regulations and other changes in the market, and by developing ready-made solutions we enable pharmacists to spend their time providing healthcare to their customers," said Christine Morris, pharmacy marketing manager.

"By offering total flexibility, we give pharmacists the freedom to choose whatever suits their business best. Our aim is to introduce new services to support AAH pharmacists and give them a competitive edge."

Key Vantage services include:

- Category management and merchandising to help pharmacists make the most of their space, increase profitability and supply the brands, medicines and products that shoppers want, using the latest research and trends data
- Advice and training on all aspects of the pharmacy contract, from SOPs to MURs
- 15 Vantage health match healthcare services such as weight management, lifestyle assessments and diabetes screening
- A growing range of own label products, including health & beauty, which offer customers value for money and give pharmacists excellent revenue opportunities.

2007 AAH conference

From pharmacy in Scotland and Wales to PBC and foundation trusts, delegates at AAH Pharmaceuticals' conference in Singapore heard about the opportunities available to them. **Gary Paragpuri** and **Patrick Grice** report

Market forces: Singapore's Little India offered something different for tourists

Foundation partnerships

Community pharmacists who want to roll out new health services should consider working with foundation trusts, a senior NHS chief executive told delegates at the AAH conference.

Foundation trusts are not accountable to the Department of Health or strategic health authorities and are free to decide how they provide their services, said Patrick Geoghegan, chief executive of South Essex Partnership NHS Foundation Trust.

"I'm accountable to my commissioners, but how I provide my services is entirely up to me...I can subcontract those services to anyone who can help me meet my targets," Mr Geoghegan said

He urged pharmacists to consider working in joint ventures with foundation trusts to "maximise what we can do together. You've got to start thinking of new ways of working. Don't be frightened to challenge," he added.

Foundation trusts could offer choice for their patients by working with pharmacists but the initiative had to come from pharmacists, he said.

In addition, pharmacists who worked with his trust would have the benefit of having their service promoted to his trust's 10,000 members, said Mr Geoghegan.

What are NHS foundation trusts?

- Set up by Parliament to provide NHS services; have no shareholders; surpluses are reinvested in services.
- Free from central control to provide local services for local people.
- Have financial freedom.
- Deliver community involvement in NHS services
- Board of governors set strategic direction.

How pharmacists can help foundation trusts tackle mental health

- Raise awareness of mental health problems; provide information and signpost to other services.
- Advise on side effects of mental health medicines, and liaise with GPs and community services.
- Work with GPs on prescribing issues around mental health; carry out clinical audits.
- Offer medication management service to improve concordance and cut side effects.
- Provide outreach and domiciliary service.
- Provide instalment dispensing, supervised administration, blood monitoring.
- Become a pharmacist with a special interest.

Pharmacy in Scotland

The speaker: Harry McQuillan, chief executive, SPGC.
The topic: Pharmacy in Scotland.
The new contract's minor ailment service:
• 700,000 patients have been registered since the launch in June 2006.
• Supporting IT infrastructure is in place with link to national patient database.
• Most commonly prescribed items are: paracetamol, ibuprofen, pholcodine, pseudoephedrine, malathion, chloramphenicol, clotrimazole, aciclovir, chlorphenamine, citric acid.
The new contract's public health service:
• Launched in June 2006 and allows pharmacists to make opportunistic interventions.
• Recognises the role of pharmacists as public health practitioners.
• Tier 2 of service includes window displays; four national health campaigns (first will promote minor ailment service).
The new contract's acute medication service:
• Involves barcoded prescriptions from September 2007.
• Contractors will be incentivised to use e-messages.
The new contract's chronic medication service:
• Due to start April 2008.
• Will involve patient registration, will be patient-led and will treat patients with long-term conditions.
• Pharmacists will agree pharmaceutical care plan with patient.
• Allows for serial dispensing.
• Will introduce e-pay for reimbursement.
• Clinical specifications still under negotiation but likely to include monitoring of patient's progress, recording of pharmaceutical care issues, and pharmacists will be able to adjust doses or medicines.
What's next after the new contract?
• Enhanced public health role for pharmacy.
• Pharmacy as first port of call for patients accessing NHS services.
• Access to e-health records.

Pharmacy in Wales

The speaker: Mark Griffiths, chairman, Cambrian Alliance.
The topic: Pharmacy in Wales.
The threats:
• Downward pressure on profits: PPRS adjustments have made a "significant number of parallel imports unviable" and category M generics, where "more and more purchase profit is being taken out" of pharmacy.
• Time constraints of the new contract: "More time is being spent on bureaucracy and less on patients, which to me seems to defy the objective of focusing on patient-centric services."
• The power of the multiples: "They can negotiate stronger deals and their enhanced infrastructure enables them to compete on a national as opposed to local scale."
• Manufacturers' quotas and agency schemes: "Cambrian Alliance members have reported significant incidents of shortages of everyday prescription medication."
The opportunities:
• Continued control of entry: "The Welsh Assembly has rejected the OFT's recommendations on new contract applications... but there'll be no false sense of security – we'll be alert to any future moves in this direction."
• National pharmacy board in Wales has been a "highly important move" and will take the lead in promoting pharmacy to government, NHS bodies and other health and social care organisations. "It will add weight and power to the collective elbow."
Key NHS publications:
• In 2006, NHS Wales launched a series of service development and commissioning directives to cover each of the main chronic diseases, with the first dealing with arthritis and chronic musculoskeletal conditions. "Each opens up significant opportunities for greater community pharmacy involvement."
The new contract:
• Implementation in Wales has been successful; £142 million has been set aside as the equivalent global sum to fund the contract, with £3m earmarked for advanced services and £4m for IT developments.
• Local health board monitoring of the contract's implementation has "gone well", with most boards adopting a supportive partnership approach.
• Most LHBs have commissioned one or two enhanced services, such as flu vaccination uptake and out-of-hours palliative care, and 2007 could see some LHBs commission warfarin monitoring and chlamydia screening
Outstanding issues:
• Need better promotion of pharmacy services to patients
• Contractors in Wales have been generally slow to implement accreditation training and invest in consultation areas for advanced services"
• MUR take up has been slow and despite "strong indications that numbers are rising, there is likely to be a significant underspend on the advanced services budget

PBC rollout

The speaker: Michelle Webster, assistant director, PBC development programme
The topic: PBC
The challenges:
• Waning enthusiasm from GPs.
• Ongoing primary care reconfigurations have stifled GP innovation.
• Lack of good data to support innovation
• Risk adverse mentality stifling innovation.
The benefits:
• Improved working relationships between GPs and relevant stakeholders, such as pharmacists.
• Shared understanding and vision between practices and PCTs.
• Good systems in place to collect data and monitor budgets and outcomes.
What pharmacists could do under PBC:
North Sheffield *H pylori* testing and treating service
• GP refers patient to pharmacist for *H pylori* breath test.
• Pharmacist tests patient and treats with eradication therapy under PGD.
• Pharmacist offers advice on management of dyspepsia and communicates results to GP.
• Service, which saved £16,000 on gastroscopies, has been rolled out across the city
Hillingdon PCT primary care diabetes management service
• All adult diabetics taking medicines can have at least six consultations with a pharmacist in any 12-month period.
• Pharmacist measures blood glucose, BP, HbA1c and cholesterol.
• Pharmacist refers patient to GP if measurements fall outside referral criteria.
• Service now delivered through all pharmacies in Hillingdon PCT and is being adapted to incorporate supplementary prescribing.

Dispensing robots the answer to increasing script volume

Dispensing 'robots' are becoming a cost-effective option for pharmacies dispensing 10,000 or more items a months, suggests George Romanes, who has been using a Consis A2 machine that cost £50,000 in his Dunns Pharmacy for nearly four months.

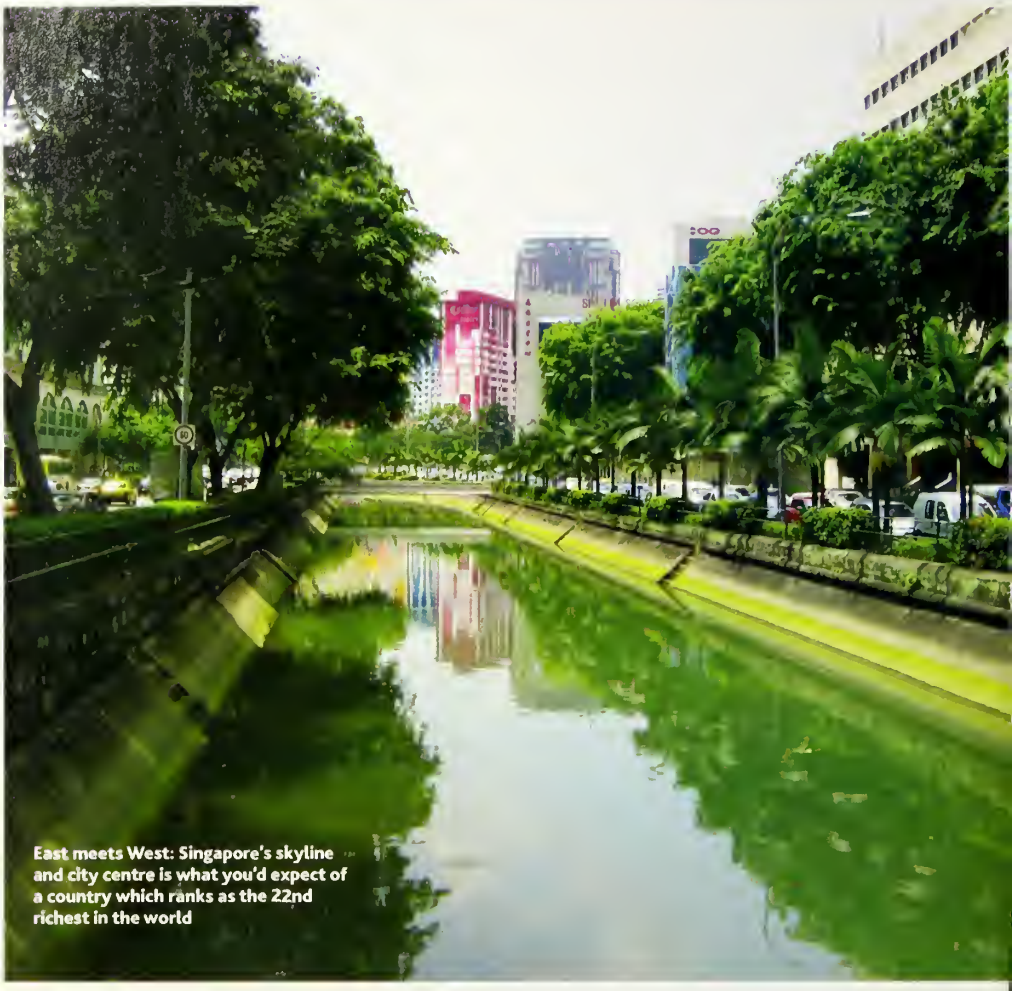
"With prescription volume going up year on year you can't cope with the number of scripts without changing the way you work," he argues. It also offers scope to reduce dispensing errors and gives more time for face-to-face contact with patients. It optimises staff resources and the use of physical space within the dispensary.

While automated dispensing machines from companies such as ARX can cost in the region of £130,000, Mr Romanes decided to opt for a less expensive option and follow the 80:20 principle – his machine would manage the 20 per cent of script lines that accounted for 80 per cent of his dispensing volume.

His Consis A2 module from Willach (distributed in the UK by Healthpoint) interfaces with his Link dispensary system using software developed by AAH. Two computers are linked to the robot, which delivers script items down two chutes. The system has been operating now for 14 weeks and has proved robust during that time. The pharmacy is dispensing 10,000 items a month and the robot is 'saving' the equivalent of half a full time dispensing technician, estimates Mr Romanes.

The Consis module operates in a similar way to a vending machine. It stocks 510 lines or 3,600 packs. Stock is loaded into chutes at the rear of the unit and picked by a claw from the front. This means the unit can be restocked while dispensing is underway.

Patients find the machine fascinating, says Mr Romanes. It does save time and there is less stress in checking scripts. Using the barcode on packs to ensure the right product is dispensed is a useful safety measure. However, for this to be effective you do need to ensure some continuity of supply and product coding, particularly important with generics and parallel imports.



East meets West: Singapore's skyline and city centre is what you'd expect of a country which ranks as the 22nd richest in the world

PCTs stumbling block for Weldricks ETP rollout

Getting smartcards and payment for N3 connectivity out of PCTs were two difficulties encountered by Weldricks when ETP was rolled out across its 53 pharmacies, according to managing director David Vanns.

The company was not involved in any EPS pilots, but having monitored developments decided to install ETP across the whole estate ahead of any "national dash for EPS".

The company's pharmacies already had broadband, but had to upgrade to N3. A single point of contact was set up with AAH for the whole project, and work went ahead to a rigid schedule.

"Smartcards were quite an issue with 53 pharmacies and locums across a number of PCTs," said Mr Vanns. "If PCTs had been left to their own devices it could have been chaotic, so we set up registration sessions."

He was critical of the three to four month delay that occurred while getting payments out of PCTs for N3 connectivity. It amounted to a substantial sum across a large number of branches, he pointed out.

The number of Link users has climbed to 2,763 since Link Evolution was launched towards the end of 2005, according to AAH's customer technology controller Leon Rudd.

"AAH is working across all the national IT programmes, and has recently recruited an additional eight programmers to allow us to do this," he said. Link is viewed as a strategic application within AAH and there are no plans to make it available to non-AAH customers.

Link is focused on a dispensing model, but will need to support services in future, he said. Systems will need to interact and share clinical records. It is also likely that PCTs will start auditing IT systems, particularly if activities are linked to payments.

Looking ahead, Mr Rudd predicted 'always on' and wireless applications, with laptops offering a mobile workstation. Clinical information and patient leaflets would be available via N3 from a central server where they were easier to keep up to date. Services will also be sold down the broadband connection.

> "AAH is working across all the national IT programmes"

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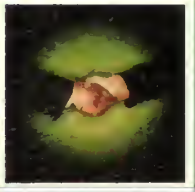

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Singapore fling

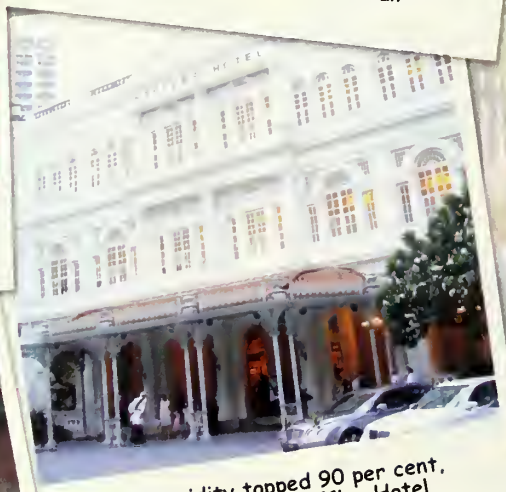
From Singapore Slings at Raffles Hotel to a Pirates of the Caribbean afternoon, there was something for everyone at the AAH conference in Singapore, reports **Gary Paragpuri**

East meets West as Pfizer Consumer Healthcare's Claire Conroy and McNeil's David Mitchell enjoy the waterfront dinner

Flexible friends: pharmacists party on the beach at the Pirates of the Caribbean evening

Hot stuff. Fire breathing dancers at Sentosa Island

Golf competition winner Michael Cann from Actavis at the Emperors Ball Gala dinner



As the humidity topped 90 per cent, delegates headed to Raffles Hotel for a Singapore Sling or two

Film star: Nucare's Mahesh Shah looks the part at the Bollywood evening

Nalini and Kirit Patel from Day Lewis at the East meets West evening

Incognito: spot the pharmacists at the Bollywood evening

Final night: last-minute photo opportunities at the Gala dinner

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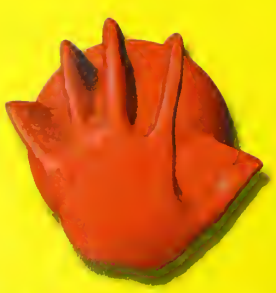

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